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Agenda

Dorset County Council

Meeting: Dorset Health Scrutiny Committee

Time: 10.00 am

Date: 14 November 2016

Venue: Committee Room 1, County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ

Ronald Coatsworth (Chairman)	Dorset County Council
Bill Batty-Smith (Vice-Chairman)	North Dorset District Council
Ros Kayes	Dorset County Council
Paul Kimber	Dorset County Council
Mike Lovell	Dorset County Council
William Trite	Dorset County Council
David Jones	Dorset County Council
Tim Morris	Purbeck District Council
Peter Shorland	West Dorset District Council
Alison Reed	Weymouth & Portland Borough Council
Peter Ogglesby	East Dorset District Council
Colin Jamieson	Christchurch Borough Council

Notes:

- The reports with this agenda are available at www.dorsetforyou.com/countycommittees then click on the link "minutes, agendas and reports". Reports are normally available on this website within two working days of the agenda being sent out.
- We can provide this agenda and the reports as audio tape, CD, large print, Braille, or alternative languages on request.
- **Public Participation**

  Guidance on public participation at County Council meetings is available on request or at http://www.dorsetforyou.com/374629.

  Public Speaking

  Members of the public can ask questions and make statements at the meeting. The closing date for us to receive questions is 10.00am on 9 November 2016, and statements by midday the day before the meeting.

Debbie Ward
Chief Executive

Contact: Jason Read, Democratic Services Officer
County Hall, Dorchester, DT1 1XJ
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Date of Publication:
Friday, 4 November 2016

1. **Apologies for Absence**

To receive any apologies for absence.

2. **Code of Conduct**

Councillors are required to comply with the requirements of the Localism Act 2011 regarding disclosable pecuniary interests.

- Check if there is an item of business on this agenda in which the member or other relevant person has a disclosable pecuniary interest.
- Check that the interest has been notified to the Monitoring Officer (in writing) and entered in the Register (if not this must be done on the form available from the clerk within 28 days).
- Disclose the interest at the meeting (in accordance with the County Council's Code of Conduct) and in the absence of a dispensation to speak and/or vote, withdraw from any consideration of the item.

The Register of Interests is available on Dorsetforyou.com and the list of disclosable pecuniary interests is set out on the reverse of the form.

3. **Minutes** 5 - 10

To confirm and sign the minutes of the meeting held on 6 September 2016.

4. **Public Participation**

(a) Public Speaking

(b) Petitions

5. **Dorset County Hospital Strategy** 11 - 18

To consider a report by Nick Johnson, Director of Strategy and Business Development, Dorset County Hospital NHS Foundation Trust.

6. **Safe and Sustainable Neonatal Services at Dorset County Hospital - Re-Designation.** 19 - 34

To consider a report by Sian Summers, Service Specialist, Specialised Commissioning – NHS England South.

7. **Weldmar Hospicecare Trust Quality Account for 2015/16** 35 - 68

To consider a report by Caroline Hamblett, Chief Executive, Weldmar Hospicecare Trust.

8. **Dorset Healthcare University Foundation Trust CQC March 2016 inspection** 69 - 78

To consider a report by Sally O'Donnell, Dorset Healthcare University Foundation Trust.

9. **Joint Health Scrutiny Committee re Clinical Services Review - Update** 79 - 86

To consider a report by the Interim Director for Adult and Community Services.

10. **Continuing Healthcare** 87 - 108

To consider a report by Paul Rennie, NHS Dorset Clinical Commissioning Group.

11. **Briefings for Information/Noting** 109 - 126

To consider a report by the Interim Director for Adult and Community Services (attached). This report includes the following items:-

- Quality Account update: Dorset County Hospital
- Dorset Health Scrutiny Committee Forward Plan
- Director of Public Health Annual Report 2016

12. **URGENT ITEM - Dorset Clinical Commissioning Group's Draft Primary Care Commissioning Strategy and Plan**

On 6 September 2016 Dorset Health Scrutiny Committee received a report by NHS Dorset Clinical Commissioning Group regarding changes to General Practice Commissioning and Locality Working. The report outlined the changes to commissioning arrangements and the pressures on services and noted that a Primary Care Commissioning Strategy was being developed and would be presented to the Primary Care Commissioning Committee (PCCC) in October 2016. Members agreed that they would like to receive a further report re the Strategy at their meeting in March 2017.

However, the publication of the Draft Primary Care Commissioning Strategy in October 2016 has raised concerns as to the nature and scale of changes being suggested within 'blueprints' for each Locality, in addition to concerns about the degree to which such changes have been subject to consultation and engagement. The Dorset Health Scrutiny Committee have therefore invited the Clinical Commissioning Group to send a representative to their meeting on 14 November 2016 to respond to questions. As these concerns did not come to the attention of the Committee until 10 November it was not possible to include a formal report in the published agenda papers within the required timescales. It is therefore necessary to add it as a matter of urgency.

To provide context and further information, the Draft Strategy is available to view via the following link;

http://www.dorsetccg.nhs.uk/aboutus/primary-care-strategy.htm

The NHS Dorset Clinical Commissioning Group have also circulated the following statement;

We want to be absolutely clear that we have no plans to close any practices and any claims that we do are inaccurate. We are in fact actively working across Dorset to support practices where they are facing the greatest pressures. Primary Care faces a number of challenges in the future, and if we continue as we are doing, our workforce and finances could soon become overstretched.

The draft Primary Care Commissioning Strategy and Plan considers how services could be delivered differently to ensure they are safe and sustainable for the future; for example consolidation of sites or back office functions. This draft version of the strategy which is on our website has been circulated to key stakeholders to gain their views.

Our ongoing strategy is to work with local groups of practices to help shape the way in which we will deliver services to meet future population needs. This includes looking at how we would support new models of care.

It is up to individual GP surgeries to decide whether to merge or not as they are independent contractors, we cannot force any change.

We have been listening to the pressures that General Practice faces and it is clear that practices will have to work together and explore new ways of working and looking at transforming the way care is delivered if we want to ensure that services are sustainable in the future.

13. **Questions from County Councillors**

To answer any questions received in writing by the Chief Executive by not later than 10.00am on 9 November 2016.

Dorset Health Scrutiny Committee

Minutes of the meeting held at County Hall, Colliton Park, Dorchester, Dorset, DT1 1XJ on Tuesday, 6 September 2016

Present:
Ronald Coatsworth (Chairman)
Bill Batty-Smith (Vice-Chairman)

Members Attending
Paul Kimber, Dorset County Council
Mike Lovell, Dorset County Council
Peter Shorland, West Dorset District Council

Officers Attending:
Ann Harris (Health Partnerships Officer)
Harry Capron (Assistant Director for Adult Care, Dorset County Council)
Jason Read (Democratic Services Officer, Dorset County Council)
Patricia Miller (Chief Executive, Dorset County Hospital)
Julie Pearce (Chief Operating Officer, Dorset County Hospital NHS FT)
Karen Fisher (Locality Manager, Dorset HealthCare University NHS Foundation Trust)
Kerry White (Director of Operations, Yeovil District Hospital NHS FT)
Yvette Pearson (Principal Programme Lead, NHS Dorset Clinical Commissioning Group)
Phil Richardson (Director of Design and Transformation, NHS Dorset Clinical Commissioning Group)
Luna Hill (Principal Primary Care Lead, NHS Dorset Clinical Commissioning Group)
Martyn Webster (Manager, Healthwatch Dorset)
Annie Dimmick (Research Officer, Healthwatch Dorset)
Des Persse (Director of Services - Help and Care, Healthwatch Dorset)

(Note: These minutes have been prepared by officers as a record of the meeting and of any decisions reached. They are to be considered and confirmed at the next meeting of the Committee to be held on **Monday, 14 November 2016**.)

Apologies for Absence

30 Apologies for absence were received from Alison Reed (Weymouth and Portland Borough Council), Peter Oggelsby (East Dorset District Council) and William Trite (Dorset County Council).

Code of Conduct

31 There were no declarations by members of disclosable pecuniary interests under the Code of Conduct.

Minutes

32 The minutes of the meeting held on 7 June 2016 were confirmed and signed.

Public Participation

33 Public Speaking

There were no public questions received at the meeting in accordance with Standing Order 21(1).

There were no public questions received at the meeting in accordance with Standing Order 21(2).

Petitions

There were no petitions received at the meeting in accordance with the County

Council's Petition Scheme.

Delayed Transfers of Care

34 The Committee considered a report by the Assistant Director for Adult Care (Dorset County Council), which outlined some of the reasons behind the number of delayed transfers of care and the work being done to decrease the number.

Monthly reporting on performance placed Dorset in the bottom quartile with high numbers of delayed transfers in both acute and non-acute hospitals. It was explained that 'red days' were identified times for when a patient was in hospital waiting for treatment or care. The aim was to reduce the number of red days for all patients. Following support from NHS England, Royal Bournemouth Hospital and their partners had developed a 42 point action plan. There were already robust processes in place to monitor and agree delayed transfers of care so the action plan focused on improving patient flow.

There would be a focus on moving patients back into their own homes as soon as they were ready. Care assessments would be carried out after the patient had returned home in order to avoid any delays with transfers. It would also help identify a more appropriate care package if patients were assessed within their own homes. Some members raised concerns that if the assessments were not completed before patients left hospitals, there would be a delay in putting care packages in place, and patients would be returning home without the appropriate levels of support required. Members were reassured that work in this area was a priority and care assessments would be undertaken for all patients as soon as they were back home.

It was noted that Poole and Bournemouth had a smaller number of delays than Dorset. It was explained that Dorset had eleven community hospitals and five acute hospitals to work with, significantly more than Poole or Bournemouth. This had an impact on the number as over 50% of Dorset's delays were caused by community hospitals. In order to improve the situation, community hospital staff were undertaking specialised training around discharges.

Noted

Care Quality Commission Inspection of Dorset County Hospital NHS Foundation Trust

35 The Committee received a presentation from the Chief Executive (Dorset County Hospital) and the Chief Operating Officer (Dorset County Hospital) which gave an update on the results of the Care Quality Commission (CQC) Inspection of Dorset County Hospital NHS Foundation Trust and the actions put in place following it.

Dorset County Hospital was rated overall as 'Requires Improvement'. In total, of the 39 factors assessed, the Trust received 'Good' ratings for 25 in total, which was 64%. The Trust was now hosting a Quality Summit with the CQC, Clinical Commissioning Group, NHS Improvement and other stakeholders on August 30th 2016. The summit would develop an action plan to address the improvements required. The final action plan would be submitted to the CQC on the 30 September 2016.

The presentation and accompanying report highlighted each of the areas inspected by the CQC and outlined the ratings given. This would help identify work that would need to be undertaken as part of the action plan. It was noted that although there were several areas that required improvement, the CQC had not identified any issues with the quality of care or staff competencies in any area. The areas for improvement were largely around recruitment issues and process.

Members asked if there would be enough funding available to make the improvements required. It was explained that the NHS' previous year overspend was roughly £2.5bn. As a result, savings had to be found nationally and this would impact

on available funding. However, a robust strategy had been put in place to identify savings whilst delivering the improvements required.

Noted

Fobbed Off - Some Experiences of Making a Complaint about NHS Foundation Trusts in Dorset

36 The Committee received a report by Healthwatch Dorset which outlined some experiences of how people had felt about the way in which their complaints had been handled.

People's experiences of what happened when they raised a concern or complaint about a service they have received from the NHS had been of particular interest for the Healthwatch network nationally. In 2014 the national body, Healthwatch England, published a report called "Suffering in Silence", which set out what people had told local Healthwatch around the country about their experiences of making a complaint. It highlighted the importance of listening and learning when care goes wrong and handling complaints effectively.

In 2015, responding to the work undertaken in this area by Healthwatch, the Secretary of State for Health made clear his belief that more could be done on the local scrutiny of complaints handling. As a result, Healthwatch Dorset approached the four NHS Foundation Trusts in Dorset with a proposal that they invite everyone who had brought a formal complaint against any of those Trusts in 2015 to share with them their experiences of the complaints process and to highlight any issues that they may have faced in that process. One of the Trusts had been unable to participate at the time but with the involvement of the other three Trusts, the survey was carried out in the early months of 2016.

The survey received 158 replies, with an additional 176 comments. The vast majority of comments received were negative and many indicated that the complaints process should be independent from the Trusts. Several comments also indicated that people felt uneasy about complaining and worried that any complaint submitted would hinder their future care needs.

The report highlighted identified the following actions that needed to be undertaken to improve the complaints experience for patients and their families;

- better use of the Patient Advice and Liaison Service
- requirement for staff training around complaints and personal skills
- better access to information
- regular and effective communication
- making sure patients and families are aware of their rights

The Trusts would be meeting with Healthwatch Dorset to discuss the exercise and talk through the findings of the survey. Healthwatch Dorset would support each of the Trusts in developing an action plan to undertake the improvements required.

Some members raised concerns that the same issues around complaints had been raised for the past 20 years and nothing had improved. It was noted that Trusts often took a defensive standpoint in response to when a simple 'sorry' would often be enough to satisfy the complainant.

The Chief Executive for Dorset County Hospital explained that there had been a reduction in formal complaints received, and the Trust often received comments rather than complaints. She informed the Committee that she personally read and

replied to every complaint received. If the same complainant had multiple issues they were invited to meet with her to discuss the issues. The Committee were reassured that complaints were taken very seriously.

Noted

NHS Dorset CCG - Changes to GP Commissioning and Locality Working

37 The Committee received a report by the Director of Design and Transformation for the Dorset Clinical Commissioning Group (CCG). The report had been drafted following a previous request by the Committee. It outlined the changes to General Practice and the progress with these changes. Under the terms of a Delegation Agreement with NHS England Wessex the CCG now had responsibility for General Practice Commissioning, Primary Care development, the Design and Implementation of Local Incentive Schemes, General Practice Budget Management and Contract Monitoring.

It was explained that there were currently 560 General Practitioners (GPs) in Dorset. Of those, 16% were aged over 55 years. This had raised some concerns due to 55 being the average age at which GPs retired or stopped doing primary care work. 32% of Dorset's nurses were in the same positon and this was causing massive pressures for primary care staff. Work was being undertaken to help address the pressures and help balance the workloads across Dorset.

Staff recruitment was being looked at for the Dorset area. There would be a focus on making Dorset a more attractive place to work in primary care. Very few people trained and qualified in general practice became GPs and work was required to look at how this area of work could be made more attractive. There was also some work being done to try and ensure that the right people were working in the right places. Better use of hospital facilities and community hospital resources were being explored to try and ease the pressure on primary care services.

Members raised concerns that although taking advantage of community hospital resources was a good idea, some people in more rural areas may not be able to find transport to these facilities and this would become an issue if services were not provided by local GPs. It was explained that the CCG needed to look at how care could be delivered without patients needing to move or travel. There was a requirement to be flexible around the services delivered. GPs in North Dorset were working hard to achieve this and deliver services closer to home. The Director of Design and Transformation (CCG) had met with Dorset County Council to look at what transport was available and what needed to be in place. The idea was to combine delivering closer to home care with the limited transport resource, along with technology to achieve a more flexible and efficient service.

Noted

E-zec - Patient Transport Service

38 The Committee considered a report by the Director of Design and Transformation (CCG), which provided an overview of the current patient transport service commissioned by CCG with E-Zec which was a service provided by NHS, for patients that are medically assessed as not safe to travel. The report outlined the current position, monitoring the performance of the service so far. The plan was to report back to the Committee with the findings at a later date with more information around performance and detail of service.

Noted

Joint Health Scrutiny Committee (Clinical Services Review) - Update Briefing

39 The Committee considered a report by the Interim Director for Adult and Community Services (Dorset County Council) which outlined the work being done by the Joint

Health Scrutiny Committee on the Clinical Services Review.

Noted

Matters for Potential Joint Health Scrutiny Committees: South Western Ambulance Service NHS Foundation Trust (Independent Review and CQC Inspections) and Community Dental Services in East Dorset

40 The Committee considered a report by the Interim Director for Adult and Community Services (Dorset County Council). The report outlined two matters on which discussions had taken place with a view to convening Joint Health Scrutiny Committees with Bournemouth Borough Council and the Borough of Poole, but which Dorset members may wish to scrutinise independently.

The Borough of Poole had agreed to host a joint meeting around the South Western Ambulance Service NHS Foundation Trust 111 service. Members agreed that Dorset should be involved with the joint committee. Nominations to this committee would be sought via email following the meeting as only four members of the committee were present at the time.

It was explained that there was also a potential need for a joint committee around Dental Services. However, a report was currently being written on the matter which may resolve some if the identified issues so the committee would not be established until the report had been published. Officers would contact Bournemouth Borough Council and the Borough of Poole to inform them that Dorset wished to take part in the potential joint meeting if it was required.

Resolved

1. That officers seek nominations for a potential joint committee on South Western Ambulance Service NHS Foundation Trust 111 service via email after the meeting.
2. That officers inform Bournemouth Borough Council and the Borough of Poole that Dorset County Council were in favour of establishing a joint committee meeting to look at dental services.

Briefings for Information/Noting

41 The Committee considered a report by the Interim Director for Adult and Community Services (Dorset County Council). The report updated the Committee on the following matters;

- Healthwatch Dorset – Summary of Annual Report 2015/16
- Dorset Health Scrutiny Committee, Annual Report 2015/16
- Draft Dorset Joint Health and Wellbeing Strategy, 2016 to 2019
- Dorset Health Scrutiny Committee Forward Plan

Noted

Questions from County Councillors

42 No questions were asked by members under standing order 20(2).

Meeting Duration: 10.00 am - 12.45 pm

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	14 November 2016
Officer	Nick Johnson, Director of Strategy and Business Development, Dorset County Hospital NHS Foundation Trust
Subject of Report	**Dorset County Hospital Strategy**
Executive Summary	Dorset County Hospital (DCH) is pleased to present its organisational Strategy to the Dorset Health Scrutiny Committee. The Strategy has been developed to take account of and align to the Dorset Clinical Services Review and the Dorset Sustainability and Transformation Plan. It is focussed around delivering the right outcomes for our patients so that safe and high quality healthcare will continue to be provided as close to our communities as possible. Our purpose remains to deliver compassionate, safe and effective healthcare; providing and enabling outstanding care for our patients in ways which matter to them. The Strategy sets out five key strategic objectives for the organisation. These objectives are underpinned by a set of key priorities. Our objectives are as follows: • Outstanding – outstanding services everyday • Integrated – joining up our services • Collaborative – working with our patients and partners • Enabling – empowering our staff • Sustainable – productive, effective and efficient The issues and challenges we face - increasing demand for services within a constrained funding environment - cannot be solved by ourselves and therefore our priorities are focussed on

	working with our partners across the health and care community to ensure we develop and deliver new models of care which are safe and effective for patients and which are clinically and financially sustainable.
Impact Assessment:	Equalities Impact Assessment: Not applicable (for DCC).
	Use of Evidence: Report provided by Dorset County Hospital.
	Budget: Not applicable (for DCC).
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW
	Other Implications:
Recommendation	It is recommended that the Dorset Health Scrutiny Committee note and comment on the content of the Dorset County Hospital NHS Foundation Trust Strategy.
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to help Dorset's citizens to remain safe, healthy and independent.
Appendices	1 Presentation slides – DCH 2020 Vision: Strategy
Background Papers	None.
Officer Contact	Name: Nick Johnson Tel: 01305 254643 Email: Nicholas.Johnson@dchft.nhs.uk

Dorset County Hospital NHS
NHS Foundation Trust

DCH 2020 Vision: Strategy

Outstanding care for our patients in ways which matter to them

Dorset County Hospital NHS
NHS Foundation Trust

What do the next few years look like for DCH?

- A major challenge and an exciting future
- Actions following CQC inspection
- Financial challenge across the NHS and Dorset health system
  - Further substantial increases in NHS funding are very unlikely
  - For 2016/17 DCH is forecasting a deficit of £1.8m including £6.7m savings target
- We must focus on **both** quality and financial sustainability
- We will achieve our goals by thinking as a system
- **This will require fundamentally changing how and where services are delivered.**

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

Dorset County Hospital NHS
NHS Foundation Trust

Our Focus

Our Purpose

Delivering compassionate, safe and effective healthcare.

Providing and enabling outstanding care for our patients and communities in ways which matter to them.

Our Mission

To play a leading role, in collaboration with our partners, in the development of an integrated, patient-centred health and care system

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

3

Dorset County Hospital NHS
NHS Foundation Trust

Our strategic objectives

INTEGRATED
Joining up our services
Target - No delayed discharges

COLLABORATIVE
Working with our patients and partners
Target - 97%+ on friends and family test

OUTSTANDING
Outstanding services everyday
Target – Rated outstanding by our regulator

ENABLING
Empowering our staff
Target - Staff engagement in the top 20% nationally

SUSTAINABLE
Productive, effective and efficient
Target - An operating surplus of 1%

4

Dorset County Hospital NHS
NHS Foundation Trust

How will we achieve this?

Playing our part in the Dorset sustainability and transformation plan (STP)

- Acute care network
- Integrated community services
- Prevention at scale

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

Dorset County Hospital NHS
NHS Foundation Trust

OUTSTANDING

Delivering outstanding services everyday

We will be one of the very best performing Trusts in the Country delivering outstanding services for our patients

Our priorities to achieve this objective are:
To place the patient at the centre of all we do ensuring safe, effective and caring services
To develop a culture of continuous improvement, supporting clinical teams to improve quality, safety and efficiency
To look within our organisation and ensure services are joined-up and integrated across specialities to the benefit of the patient
To implement a comprehensive and robust governance approach across the organisation
To develop an excellent administrative care pathway that helps patients access services quickly and easily

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

Dorset County Hospital NHS
NHS Foundation Trust
Our priorities to achieve this objective are:

INTEGRATED

Joining up our services

We will drive forward more joined up patient pathways, particularly working more closely with and supporting GPs.

Our priorities to achieve this objective are:
To work with our partners organisations in health and social care to deliver care closer to home that is truly patient centred
To develop a healthcare hub on the DCH site working with our partners in community and primary care and in particular with our Mid-Dorset GP colleagues
To strengthen relationships with GPs, supporting the sustainability and education of the primary care sector

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

7

Dorset County Hospital NHS
NHS Foundation Trust

COLLABORATIVE

Working with our patients and partners

We will work with all of our patients and partners across Dorset to design services together that are efficient and sustainable, patient-centred, outcome-focussed services

Our priorities to achieve this objective are:
To work with our partners at Poole and Bournemouth hospitals to deliver outstanding services which reflect the needs of our local populations
To strengthen links between health and social care and mental health providers to provide joined-up services
To establish a comprehensive transformation programme for our services focussed on designing services with patients and improving their outcomes

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

8

Dorset County Hospital NHS
NHS Foundation Trust

ENABLING

Empowering our staff

We will engage with our staff to ensure our workforce is empowered and fit for the future

Our priorities to achieve this objective are:
To implement our 'People Strategy 2015' to develop the our ability to deliver safe, effective and compassionate care
To review our enabling and support services to ensure they support the delivery of our aims and objectives and meet the needs of our patients and staff
To ensure relevant data is easily accessible, in multiple locations using technology, and enabling a culture of evidence based decision making
To speed up the adoption of relevant research and innovation and define our role within science, education and training, and research and development, working with the Allied Health Sciences Network.
To appreciate and further develop our social responsibility in the community

9

Dorset County Hospital NHS
NHS Foundation Trust

SUSTAINABLE

Productive, effective and efficient

We will ensure we are productive and efficient in all that we do to achieve long-term financial sustainability

Our priorities to achieve this objective are:
To embed a culture of value management and deliver efficiency projects across the organisation, using the Carter principles as a foundation
To develop our commercial capacity and capability building commercial partnerships to help achieve this
To drive value from our assets, in particular our estates and property, and enhance the patient experience

10

Dorset County Hospital NHS
NHS Foundation Trust

What do we need to look like in the future?

Outstanding care for our patients in ways which matter to them.

Our patients and communities are healthier. We are at the centre of a sustainable care system, delivering and enabling outstanding quality of care and outcomes with our partners.

- A key partner in the delivery of the Dorset wide Plan (STP)
- Acute planned and emergency hospital for West Dorset
- The Location of the Mid Dorset integrated community services hub
- Managing care for the frail elderly and those with chronic illnesses in the community
- Using technology to the benefit of our patients
- Services are joined up with community and primary care

INTEGRITY | RESPECT | TEAMWORK | EXCELLENCE

11

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	14 November 2016
Officer	Sian Summers, Service Specialist Specialised Commissioning – NHS England South
Subject of Report	**Safe and sustainable neonatal services at Dorset County Hospital – re-designation.**
Executive Summary	Dorset County Hospital (DCH) currently has a Local neonatal unit (LNU) which treats babies from 27+ weeks when they require extra support postnatally. DCH has about 1,957 births a year in the maternity unit. In 2015/16 financial year, of 229 babies that were treated at DCH neonatal unit 17 were under 32 weeks. An average of 15 babies between 27 to 32 weeks have been delivered in the unit over the last three years. South West Neonatal Network designated DCH as a special care unit (SCU) in 2012 as part of their full service review. This was supported by the Wessex Clinical Senate but this was not enacted due to a change in the commissioning In 2015 Dorset CCG asked the RCPCH to do a report on paeds, maternity and neonatal services at DCH. Their report, published in April 2016, agreed with the findings of the South West Network recommendations for the change to the neonatal unit, citing the main reasons below and giving a 6 month timescale to implement: • Non-compliance with out of hours medical cover; • Concerns about maintenance of medical skills; • Low levels of activity including numbers of very preterm births to maintain skills. NHS England are only implementing the neonatal element of the recommendations with regard to the re- designation of DCH and not any other element of the report as these come under the purview of the CSR (clinical services review) in Dorset being run

	by the CCG. The CCG plans to go to consultation in November but any changes agreed could take up to five years to implement and therefore this does not fit with the timescale for the neonatal implementation. Under the new arrangements, the aim will be to transfer expectant mothers with threatened preterm delivery from DCH to Poole before they give birth. Transfer in utero is safer for the baby but, as it is not possible to accurately predict premature delivery, two to three times more women will need to be transferred than will deliver. This means that 30- 45 women a year may be transferred to Poole of whom around 15 of whom could be anticipated to deliver a pre-term baby. The rest will return home and most likely go on to deliver at a later date in DCH. This is established practice in other rural areas of England. The plan will always be to move the babies back to DCH or discharge home from the other units as soon as the baby is clinically fit enough for this to happen. Therefore stays in units far from home will be kept to a minimum. This approach fit with the strategy of Bliss, the national charity, which champions the right for every baby born premature or sick to receive the best care. Their strategy summary for 2016-2019 states: ”We will place premature and sick infants’ voices at the heart of decision-making to ensure that their best interests are always put first.” In term of consultation / engagement NHS England have taken this through the stage 1 assurance process and it has been confirmed that stage 2 is not required. We are involving providers, ambulance trusts and are currently arranging to discuss this with a parent interest group (the Kingfisher group). The timetable, all being equal, is for this re-designation to take effect from December 2016.
Impact Assessment:	Equalities Impact Assessment: Report provided by NHS England.
	Use of Evidence: Report provided by NHS England.
	Budget: None (for DCC)
	Risk Assessment:

	Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk: LOW (For Dorset County Council)
	Other Implications:
Recommendation	That Members note and comment on the report.
Reason for Recommendation	The work of the Committee contributes to the Council's commitment to help Dorset's residents to be safe, healthy and independent.
Appendices	Appendix 1 – Options Paper for a Safe and Sustainable Neonatal Service at Dorset County Hospital
Background Papers	Royal College of Paediatrics and Child Health, Design Review for NHS Dorset Clinical Commissioning Group, April 2016: http://www.dorsetccg.nhs.uk/news/Review-of-services-published.htm
Officer Contact	Name: Sian Summers, Specialised Commissioning – NHS England South Tel: 0113 8249935 Email: Siansummers@nhs.net

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Appendix 1

Options paper for a Safe and Sustainable Neonatal Service at Dorset County Hospital

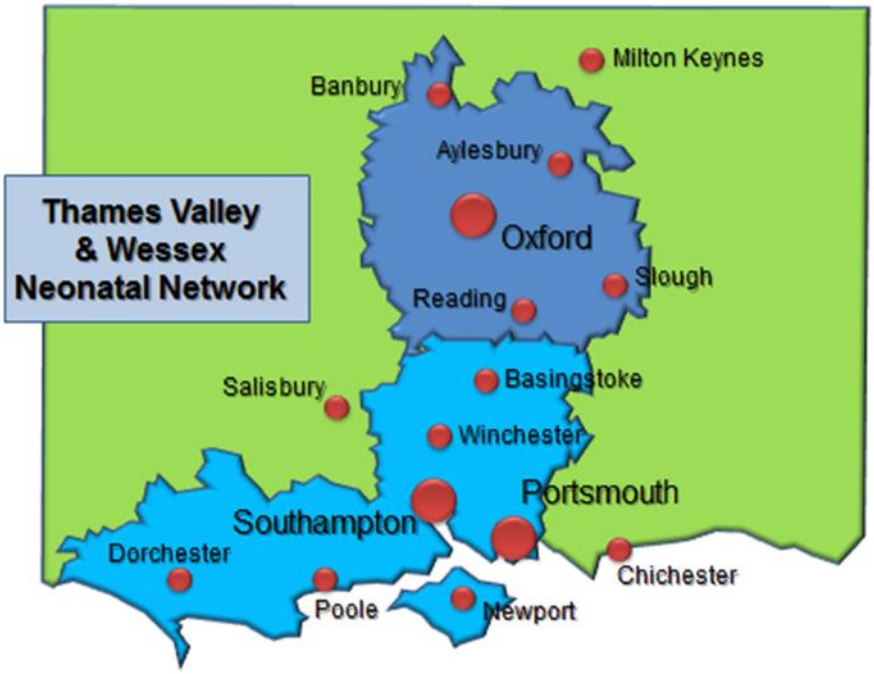
This document outlines the background and evidence supporting a change in the level of neonatal provision at Dorset County Hospital. It describes the proposed options for the Neonatal service re-designation from LNU to SCU. This work forms part of the safe re-provision of neonatal services for infants within the TV & Wessex Neonatal Network.

Neonatal care is a highly intensive environment in which nurses and doctors provide continuous support for very sick infants and their families 24 hours a day. Since 2013, services have been managed within Operational Delivery Networks. Much of the care of newborn infants, either healthy infants or with lesser problems is carried out at the district hospital where they are born. Complex and intensive care, particularly of very preterm infants, is carried out in tertiary centres. Neonatal services are the responsibility of NHS England's specialised services.

1.0 Network Structure:

Thames Valley & Wessex Neonatal Operational Delivery Network (ODN): Neonatal care for preterm and sick infants is organised into local areas around the country. Hospitals, and other NHS services for infants and their families, work together in these areas, called Neonatal Operational Delivery Networks. Thames Valley & Wessex Neonatal Operational Delivery Network provides all levels of care across 15 units hosted by 13 Trusts in local areas. These units range from special care units (SCU) through to neonatal intensive care units (NICUs). The Network facilitates collaborative working between the Trust providers enabling smooth pathways for infants and their families, especially if they need to move between hospitals. Established Network patient pathways ensure all infants have the care they need, in an appropriately designated neonatal unit, as close to home as possible.

Figure 1: Map depicts the Trust providers within Thames Valley & Wessex Neonatal ODN



For Wessex, neonatal intensive care is provided at both the Princess Anne Hospital, University Hospital Southampton NHS Foundation Trust (UHS) and Portsmouth Hospitals NHS Trust (PHT) for Wessex. UHS also provides neonatal surgery for Wessex and cardiothoracic surgery for both Wessex & Thames Valley.

Figure 2: Shows current designation of neonatal units within Thames Valley & Wessex

Wessex	
Dorset County Hospital NHS Foundation Trust DCH	LNU
Hampshire Hospitals Foundation Trust – Winchester site	LNU
Hampshire Hospitals Foundation Trust – Basingstoke site	LNU
Isle of Wight NHS Trust IOW	LNU
Poole Hospital NHS Foundation Trust PH	LNU
Portsmouth Hospitals NHS Trust PHT	NICU
Salisbury NHS Foundation Trust SH	LNU
University Hospital Southampton NHS Foundation Trust UHS	NICU
Western Sussex Hospitals NHS Foundation Trust, St Richard's	LNU
Thames Valley	
Buckinghamshire Healthcare NHS Trust, Stoke Mandeville Hospital	LNU
Frimley Health NHS Foundation Trust, Wexham Park Hospital	LNU
Milton Keynes University Hospital NHS Foundation Trust	LNU
Oxford University Hospitals NHS Foundation Trust, John Radcliffe site	NICU
Oxford University Hospitals NHS Foundation Trust, Banbury site	SCU
Royal Berkshire NHS Foundation Trust	LNU

2.0 Thames Valley & Wessex Neonatal ODN Position:

Within Thames Valley & Wessex Neonatal ODN there are several neonatal units currently designated as Local Neonatal Units (LNUs) that have very low activity when benchmarked to other LNUs & even Special Care Units (SCUs) within England.

Figure 3: Chart benchmarking activity of Thames Valley & Wessex LNUs & SCUs with LNUS & SCUs within England

- **Blue = LNU**
- **Green = SCU**
- **Red = All TV & Wessex LNUs and SCU**

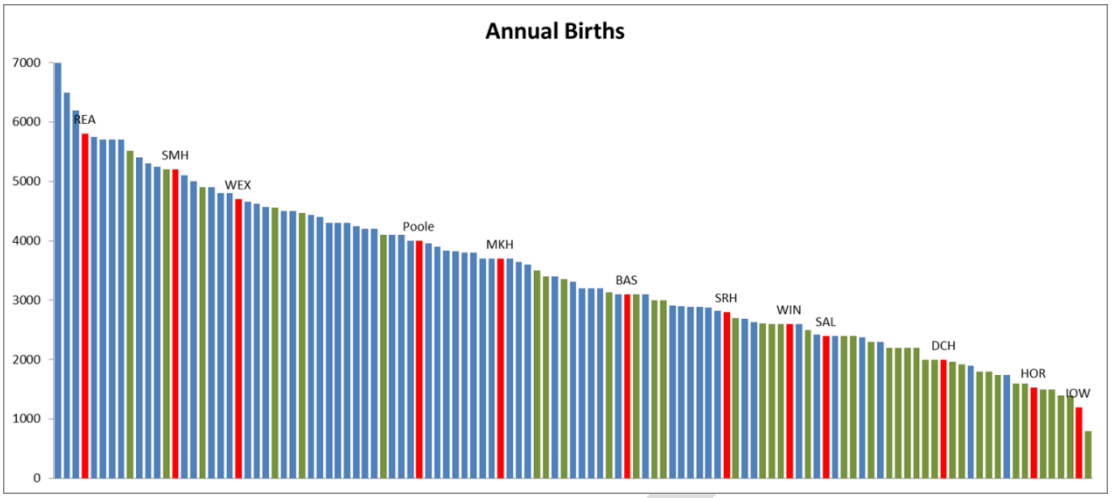
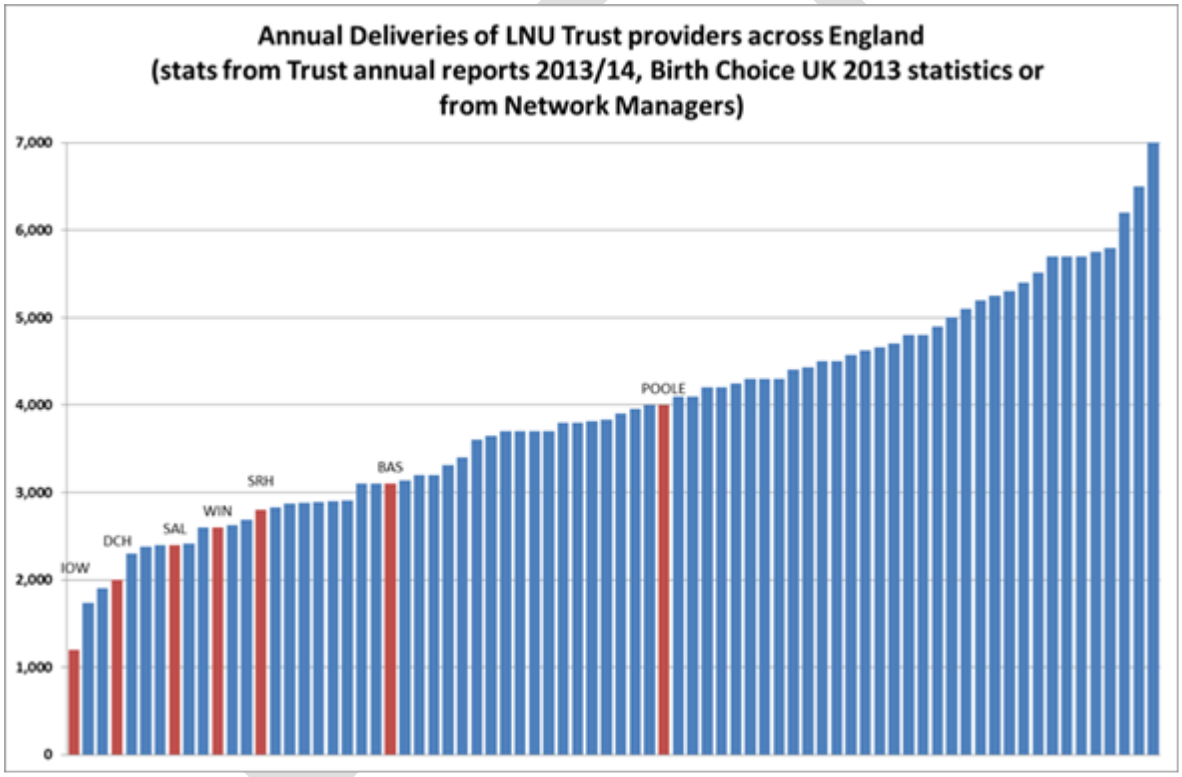


Figure 4: Chart benchmarking Wessex LNU activity with LNUs only in England



The low activity, particularly in Intensive Care (ITU) & High Dependency (HDU) of 4 LNUs, which included Dorset County Hospital, were highlighted on the Thames Valley & Wessex ODN Oversight Risk Register in June 2015 with the view that this may present challenges to meet & attain national standards for operation as an LNU[1,2,3,4,5].
This work is the first in a series to be undertaken within the network.

Background

In 2012 Dorchester neonatal services, which were then commissioned by the South West, were included in a designation process undertaken by South West specialised commissioners. The recommendation in 2012 was to designate Dorchester a Special

Care Unit which was supported by the Network. The Network at this time undertook activity modelling of new patient pathways, which demonstrated adequate capacity based at Poole Hospital. The re-designation was challenged by Dorchester services due to inequity within the Thames Valley & Wessex Neonatal Network, who were commissioned by Wessex and the South East, who were not undergoing a similar process at the time. A final letter agreeing to defer designation in the short term was sent by the Associate Director of Commissioning, South of England Specialised Commissioning Group to Dorchester Hospital, in January 2013.

In 2014 NHS Dorset CCG started to undertake a Clinical Services Review (CSR) of the provision of all health services within the county. As part of this work NHS Dorset CCG commissioned an independent review of the proposed options for maternity and children's services. The review was led by The Royal College of Paediatrics and Child Health (RCPCH). Whilst the review was precipitated by a lack of agreement about options for paediatric inpatients, it had a much broader remit and also considered whether the current maternity neonatal and paediatric services were safe, high quality and sustainable.

The RCPCH report stated that:

The ODN had put forward clear and convincing arguments for the neonatal unit at DCH to be formally designated as a Special Care Unit, reaffirming the South West network designation from 2012 and supported by the Wessex Clinical Senate. This designation is based upon comparators for other small hospitals in the region, and work is under way at other sites towards centralisation or reclassification. The rationale cites

- *Non-compliance with out of hours medical cover*
- *Concerns about maintenance of medical skills*
- *Low levels of activity including numbers of very preterm births to maintain skills*

Re-designation is likely to affect a relatively small number of infants per year. Current data shows the number of infants under 32 weeks gestation currently cared for in DCH numbers fewer than 25 per year, who would need to be cared for, at least initially, in Poole. Transfers in utero are best for the infant, so the obstetric and midwifery teams at both units would need to engage with the changed arrangements.

They also recognised that:

Even with the neonatal unit changes, most infants born at DCH who require neonatal care would continue to be cared for on the DCH site.

The RCPCH Dorset Clinical Services Review document (2016)[6] recommended that making neonatal care safer and more sustainable was considered urgent & stated:

Re-designate the Local Neonatal Unit (LNU) at Dorset County Hospital, converting it to a Special Care Unit (SCU) for infants born after 32 weeks gestation. This transition should start as soon as possible, with an urgent target date for completion. Work with Poole Hospital and the transport services to ensure safety, and with BLISS for parent communication and support.

Bliss, the national charity, champions the right for every baby born premature or sick to receive the best care. Their strategy summary for 2016-2019[7] states

'We will place premature and sick infants' voices at the heart of decision-making to ensure that their best interests are always put first.'

A separate recommendation from the review relates to Dorchester and Yeovil working together to explore combining their paediatric & obstetric services & deliver SCU on one site. Whilst this may have some impact on the activity undertaken at the unit in Dorchester this will be dealt with by the Trusts and CCGs through a parallel but separate strand of work and would not affect the re-designation of the unit.

3.0 Proposed Membership, Accountability & Governance of Implementation Group:

The project relates to the safe re-provision of neonatal services in Thames Valley & Wessex of both singleton infants & multiples <32, but with the expectation that high risk multiples eg discrepant growth may need to be transferred above this gestation. Initially the project will focus on infants <32 weeks who are currently delivered at DCH in line with RCPCH recommendations, changing the designation of DCH from a LNU to a SCU.

Pathway arrangements for infants below 27 weeks gestation or for those infants requiring NICU, in Thames Valley & Wessex care will remain the same.

Sponsor for the project Dr Vaughan Lewis – Clinical Director NHS England South
Reporting will be via the project sponsor to NHS England South Senior Management Team (SMT) with reports copied to Dorset CCG Maternity Group.

To ensure a safe neonatal pathway redesign within Dorset, good communication is essential, therefore membership for implementation will include a core working group, an extended group for specific issues and wider stakeholders for information.

Core group members of Implementation Project Group:

NHS England (Specialised services):

- Marion Eaves – Assistant Supplier Manager NHS England South
- Sian Summers – Service Specialist Specialised Commissioning
- Wendy Cottrell – Quality Assurance Lead,

Dorset Clinical Commissioning Group (CCG):

- Hannah Nettle, Principal Programme Lead Review, Design and Delivery Maternity, Family and Reproductive Clinical Commissioning Programme
- Pam O'Shea – Quality Assurance Lead

Providers:

Dorset County Hospital:

- Dr Abby Deketelaere Consultant Paediatrician, Neonatal Clinical Lead
- Catherine Abey-Williams, Divisional Operations Director

Poole:

- Minesh Khashu – Consultant Neonatologist
- Sue Whitney - Senior General Manager

TV & Wessex Neonatal Operational Delivery Network (ODN):

- Una Vujakovic – TV & Wessex ODNs Director
- Dr Victoria Puddy – Consultant Neonatologist, Wessex Clinical Lead
- Teresa Griffin – ODN Manager
- Kujan Paramanantham – Lead for Quality and Information

Ambulance services:

- Adrian South Deputy Clinical Director SWAST
- Mark Ainsworth Smith U&E Ops Director SCAS
- SONET – Dr Neelam Gupta, Consultant Neonatologist/ Dr Victoria Puddy

Extended group:

- South West Neonatal ODN – Rebecca Lemin and Exeter and Taunton reps TBC
- Healthwatch
- Comms teams – Dorset CCG and NHS England
- Linda Doherty – NHS England PoC lead south for W&C
- Somerset CCG
- Parent representative – Lorraine Phillips

Informed:

- Trusts providing neonatal care within Wessex Network
- Dorset CCG maternity working group/CSR (Karen Kirkham)
- Maternity voices
- Kingfisher group
- Liz Mearns

The implementation project group will report via the project sponsor to NHS England South SMT with reports copied to Dorset CCG maternity group

4.0 Options for future care of neonates from 27-32 weeks gestation whose mothers are booked into DCH & whose baby's require LNU care:

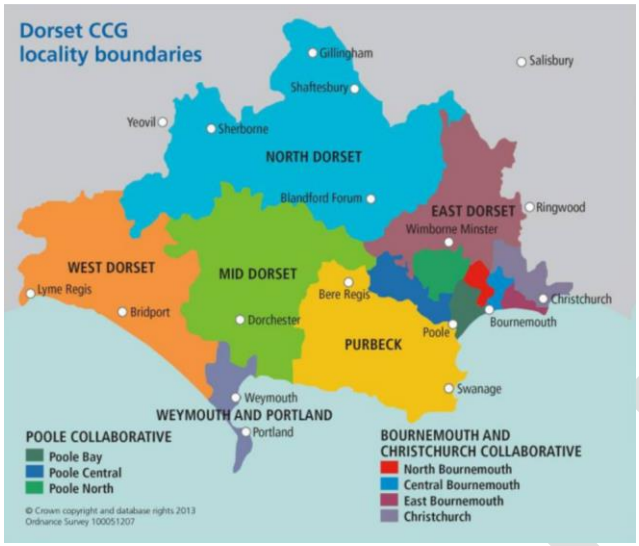
Option	Advantages	Risks	Comments
One: Do nothing	No changes for stakeholders	Safety & sustainability of LNU with low IC & HD care	Not compliant with RCPCH recommendations 2012 designation process National outlier for LNU activity
Two: Pathway to transfer mothers and infants in utero from 27 -32 weeks gestation to other Network LNUs or NICUs as appropriate. In addition consider moving in utero preterm multiples where a significant need for interventional care after birth is anticipated LNU would be Poole Hospital NHS Foundation Trust(PH) as nearest local LNU *****	Centralisation of infants who require neonatal care that can be delivered within a LNU but who do not require complex care or specialist interventions of a NICU within Dorset. Rationalisation of specialist resources required to care for complex infants Financially cost effective	Some service users, particularly those west of DCH will have greater distance to travel Unable to recruit additional neonatal & obstetric staffing & midwives at PH to accommodate increased activity Inadequate staff or capacity to manage increased neonatal capacity at PH Increase activity for ambulance services Increase SONeT neonatal transport activity Activity may increase for Wessex NICU services	Compliant with RCPCH recommendations In line with 2012 consultation

Three: Move mothers and infants from 27 - 32 weeks gestation to other LNUs or NICUs as appropriate. Dependant on where mother / baby live they will have the option of unit transferred to: • Poole Hospital NHS Foundation Trust(PH) nearest local LNU • Royal Devon and Exeter Hospital (EH) • Musgrove Hospital LNU In addition consider moving in utero preterm multiples where a significant need for interventional care after birth is anticipated	Centralisation of infants at existing units and provision of correct level of care as close to home as possible Rationalisation of specialist resources required to care for complex infants Financially cost effective	Mothers & infants would be moved out of current agreed pathways of care Inadequate staff or capacity to manage increased neonatal/obstetric/maternity activity at alternate trusts Unable to recruit additional neonatal & obstetric staffing & midwives to accommodate increased activity at alternative trusts Increase activity for ambulance services Increase neonatal transport Teams activity Activity may increase for SW / Wessex NICU services Increase need for communication/ co-ordination with more units from DCH	Compliant with RCPCH recommendations In line with 2012 consultation

The pathways for infants born below 27 weeks or/and 800grammes or those who require NICU specified care within Thames Valley & Wessex will remain the same care.

5.0 Data to support decision:

Dorchester Neonatal Admissions, by Dorset CCG Locality



Dorchester Neonatal Admissions by Dorset Locality, Booked into Dorchester

1st Episode admissions, Booked Dorchester

Locality	5 Year Average
Weymouth & Portland	81
Mid Dorset	39
North Dorset	35
Dorset West	31
Purbeck	14
Out of Dorset	8
Dorset unclear*	7
Dorset Other	4

Dorchester Neonatal Admissions, 27-32 week Infants, by Dorset Locality, Booked into Dorchester

1st Episode admissions, Booked Dorchester

Locality	5 Year Average
Weymouth & Portland	5
Mid Dorset	2
North Dorset	2
Dorset West	1
Dorset unclear*	1
Purbeck	1
Out of Dorset	0

Locality based of GP address

**Dorset unclear - BadgerNet coding insufficient to tell which area of Dorset*

Average Number of Admissions per year*, Infants 27+0 to 29+6 weeks	6 *(Range 4-9)*
Average Number of Admissions per year, Infants 27+0 to 29+6 weeks – later transferred to a NICU*	*3 (Range 1-5)*

Average Number of Admissions per year*, Infants 30+0 to 31+6 weeks	9 *(Range 6-13)*

**Data taken from the last 5 years admissions activity at DCH*

6.0 Timeline for change of re-designation of DCH to SCU:

Option	Advantages	Risks	Comments	Timeline
One **Two phase approach** **By Sept:** Step change of initially moving 27-30 weeks gestation & preterm multiples where a significant need for interventional care after birth is anticipated who are booked into DCH who require LNU/SCU care to other Network LNUs or NICUs. PH nearest local LNU or alternate providers based on patient postcode / choice *	Numbers very small so re-designation could happen immediately as limited impact on activity or capacity at PH or for Wessex NICUs when repatriating infants who have required NICU care Limited impact to SONet (Thames Valley & Wessex Neonatal Transport Service) No major impact to SCAS Politically more acceptable for stakeholders Six month plan to address any capacity staffing issues within neonatal obstetric and transport services if required	Potential confusion re destination of mothers and infants and need for another later change in system		By end of September 2016

By April 2017 Second stage moving 30-32 weeks gestation 27-32 weeks gestation & preterm multiples where a significant need for interventional care after birth is anticipated who are booked into DCH who will require LNU/SCU care to other Network LNUs or NICUs. PH nearest local LNU				By April 2017
Option 2: **"Big bang" approach** Moving all 27-32 weeks gestation preterm multiples where a significant need for interventional care after birth is anticipated & who are booked into DCH who require LNU/SCU care to other Network LNUs or NICUs with no step change		Time delay for re-designation of DCH as time would be required to ensure sufficient capacity to accommodate additional activity of neonatal & obstetric services at other trusts. Insufficient capacity at other Trusts will also have impact on NICUs capacity with repatriations. Time delay would also be required to ensure capacity for ambulance and transport services.		By April 2017 ? TBC

The pathways for infants born below 27 weeks or/and 800grammes or those who require NICU specified care within Thames Valley & Wessex will remain the same care.

7.0 Next Steps (for discussion)

- Decision to be taken on the preferred option with clear reasons
- Development of implementation plan (? Equality and quality impact assessment needed if not done already by CCG)
- Sharing/ Agreement of plan with stakeholders
- Plan taken through NHS England change assurance process if required
- Plan taken to NHS England South SMT for sign off
- Consultation (if required) with HOSC/ OSC
- Implementation

8.0 References:

1. DH Toolkit for High Quality Neonatal Services (2009) www.dh.gov.uk/en/publicationstandstatistics/Publications/PublicationsPolicyAndGuidance/DH__107845
2. NICE specialist neonatal care quality standards 2010 www.nice.org.uk/qualitystandards
3. BAPM 2010. Service Standards for hospitals providing Neonatal Care(3rd edition) www.bapm.org/publications
4. National Neonatal Critical Care Service Specification 2015 http://www.england.nhs.uk/resources/spec-comm-resources/npc-crg/group-e/e08/
5. BAPM (2011). Categories of Care http://www.bapm.org/publications/documents/guidelines/CatsofcarereportAug11.pdf
6. RCPCH Design Review of Dorset Clinical Services, commissioned by Dorset CCG http://www.dorsetccg.nhs.uk/Downloads/CSR/RCPCH/RCPCH%20Dorset%20%20Maternity%20and%20Paedatrics%207th%20April%202016%20final%20version%20for%20website.pdf
7. Reaching every baby born premature or sick. BLISS strategy summary 2016-2019 http://www.bliss.org.uk/our-strategy

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	14 November 2016
Officer	Caroline Hamblett, Chief Executive, Weldmar Hospicecare Trust
Subject of Report	**Weldmar Hospicecare Trust Quality Account for 2015/16**
Executive Summary	This is the sixth Quality Account of Weldmar Hospicecare Trust and is produced as a statutory requirement because Weldmar receives money from the NHS, and also to help the users of our services and other stakeholders to see how we work to improve the service we give. Our patients receive support from many different sources during their journey and the quality of the service they experience may be determined by the interaction of different providers as much as by any one provider alone. This report on activity in 2015/16, covers areas where we alone are responsible and it follows the statutory requirements of the regulatory authority. We hope it will be of interest to our community, our service users and commissioners. More corporate information about Weldmar Hospicecare Trust, including our latest Annual Report and Accounts, can be found on our website www.weld-hospice.org.uk
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by Weldmar Hospicecare Trust.

	Budget: Not applicable to DCC.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk: LOW
	Other Implications: None.
Recommendation	That Members note and comment on the report.
Reason for Recommendation	The work of the Health Scrutiny Committee contributes to the County Council's aim to help Dorset's citizens to maintain their health, safety and independence.
Appendices	Appendix 1 – Weldmar Hospicecare Trust Quality Account for 2015/16
Background Papers	None.
Officer Contact	Name: Caroline Hamblett Tel: 01305 215309 (PA Liz Billingham) Email: caroline.hamblett@weld-hospice.org.uk

Weldmar Hospicecare Trust
Caring for Dorset

Quality Account for 2015/2016

The Mission of Weldmar Hospicecare Trust

- To ensure all patients needing palliative care in Dorset have access to excellent services delivered when and where needed whether by Weldmar Hospicecare Trust, or by others supported by the Trust.
- To offer support to families and others affected by the patient's illness

Quality Account for 2015/2016

Contents **Page**

1. Introduction

This is the sixth Quality Account of Weldmar Hospicecare Trust and is produced as a statutory requirement because Weldmar receives money from the NHS[1], and also to help the users of our services and other stakeholders to see how we work to improve the service we give.

Our patients receive support from many different sources during their journey and the quality of the service they experience may be determined by the interaction of different providers as much as by any one provider alone. This report on activity in 2015/16, covers areas where we alone are responsible and it follows the statutory requirements of the regulatory authority. We hope it will be of interest to our community, our service users and commissioners.

More corporate information about Weldmar Hospicecare Trust, including our latest Annual Report and Accounts, can be found on our website www.weld-hospice.org.uk

[1] *At Weldmar Hospicecare Trust, the NHS only commissions a third of our beds and some 30% of the day and community work carried out by the Trust, but this report covers the whole of our work, the rest being funded from charitable fundraising, retail operations, investments and reserves. We do not have different standards for patients, depending on the source of funds for the service.*

2. Statement of accuracy and commitment to quality from CEO and Chair

Report from the CEO

I joined Weldmar Hospicecare Trust in January having worked in end of life care for 23 years. I passionately believe in ensuring people have the dignity, respect and care that they deserve at the end of their lives. I wish to ensure the services we offer are equitable, while managing a steadily growing demand not only in numbers but in the complexity of those who seek our support. Our approach to any financial challenges has been, like our care, holistic. It includes our direct services to patients and families, our education services to raise standards internally and externally, our partnerships to improve care co-ordination, our documentation and measurement of the impact of our work.

We also need not to lose sight of the fact that people who have a diagnosis of non-malignant disease, those who are on the margins of society for any reason and those who have a fearful approach to end of life services, tend not to access our services so readily as others. We have significantly changed our organisation to try and improve our accessibility for all these people by creating geographically based teams who can identify needs in their locality and tailor a response. This has required considerable upheaval for staff whose commitment to improving service quality is to be greatly applauded.

This report focuses in particular on our direct care of patients and it is very pleasing to note that we are in the vanguard of those adopting the new national Outcome Assessment and Complexity Collaborative (OACC) system for measuring the impact of care services. This toolkit, developed by Kings College London and the Cicely Saunders Institute, provides palliative care providers, for the first time, with a validated and robust method for assessing holistically patient wellbeing – and thus our efficacy. We will be reporting results from this in the next few years.

We are conscious however that we are only part of the care which surrounds our patients, and working in partnership with the NHS and other providers is key to ensuring patients and their families get the care they need regardless of their location in Dorset.

We have recently been inspected by the CQC and received an Outstanding Award which recognises the commitment and care that we give. However, we need to ensure we can reach as many people who need us as possible. We are therefore reviewing our strategy to ensure we can continue to give and grow our outstanding work.

"*People and families received outstanding care from exceptional staff and volunteers who developed positive, caring and compassionate relationships with them. The service promoted a culture that was caring and person centred. Staff worked together as a multidisciplinary team to provide seamless care for people".*
Care Quality Commission (CQC) June 2016 Inspection Report Joseph Weld Hospice."

Caroline Hamblett
Chief Executive

Report from Chair on Assurance

The Board of Weldmar Hospicecare Trust takes its responsibilities, for ensuring the service we provide is of the highest quality, very seriously. We have a rigorous clinical governance system committed to quality improvement and clinical effectiveness which generates the data reported in the next few pages. We work regularly with our NHS commissioning partners to share information and ensure that we meet their requirements for the standard of service offered. The Board receives information from all these sources on a regular basis.

We also have a comprehensive Assurance Framework which maps every area of the Trust's activities and links these into mechanisms for providing assurance to the Board that all is as is reported to us and how it should be. This framework extends over all areas as the quality of the patient experience will be as much conditioned by the recruitment, management and training of staff, for instance, as it will be by the medication we give. The accuracy of the reports received at Board meetings, and the information in this Report, is checked by rigorous independent audit staff. Their processes identify shortcomings in procedures and risk management.

We are fortunate to have the services of a Forum of Advisors. These are individuals with specific expertise in various areas who offer their help, sitting on Board committees and participating in inspections of our services which include confidential interviews with staff, patients and families and physical inspection of aspects of each facility. These inspections include visits to patients we serve in their own homes. Reports of each visit are made available to the Care Quality Commission (CQC) with whom we are registered.

In the end however the only quality measure we should rely on is the reported experience of patients and their families, and the degree to which we meet the needs of our community. Our constitution, which allows anyone interested to be a member and requires us to account to our community at two public meetings a year, gives an opportunity for their voice to be heard. We also have a well-developed public and patient involvement strategy which gives numerous opportunities for individuals to have their say and for us to listen and explore more deeply exactly what has worked well, and what improvements we can make.

Stephen Baynard
Chairman of the Board of Trustees

3. Quality Improvement work in 2015/16

The quality, resilience and commitment of our staff at Weldmar Hospicecare Trust is perhaps best illustrated by our recent inspection report from CQC. In spite of challenges due to staff sickness, particularly in the community, which necessitated a rapid review of our methods of service delivery to ensure all community patients received good care, we received an overall outstanding grade. Staff across the Trust, namely doctors, nurses and education colleagues worked as a team to ensure comprehensive cover for our patients in the community. From a position of potential weakness the response of staff turned it into a positive experience enhancing team working across boundaries and reducing silo working.

Our challenges now are to embed, as fundamental, mentorship, support and clinical supervision for all nurses, particularly in the community, if we are to continue to develop robust and resilient clinical staff.

3.1 Wellbeing

Over the past year, as part of our current strategy we have been developing 'Wellbeing Services'. Under this umbrella sits our classic day respite service, where patients come for the day, give their carers a break and enjoy a good lunch, social contact and various diversions, games and creative work. We are now also developing services such as 'breathlessness and fatigue' clinics, holding educational sessions to encourage self care, complementary therapy on an appointment basis and considering a bathing service.

The more flexible service allows for patients to pick and choose what they would like, rather than feel they must spend the whole day with us. We hope to see patients earlier in their illness too, taking the pressure off our health care partners in the community. This is promoted through the Gold Standards Framework (GSF) meetings in GP surgeries, which are attended by our Weldmar Community Nurses. This service will become part of our general strategy review over the coming months.

Blandford Wellbeing Service opening 2016

Over the years we have had the support of 'F1s' (first year post graduate doctors) in rotation for a few months from Dorset County Hospital (DCH). This has been hugely beneficial to the doctors who come, learning about end of life care and communication skills, which will help them in whichever field of practice they finally choose. In addition we have benefitted from their enquiring minds, growing confidence and expertise. Unfortunately, this is being suspended for a while due to the impact of the new junior doctor contract, changes in rotas and other factors, but we hope the rotation will start again next year with F2 doctors (who are in their second year of postgraduate training).

3.2 Education

The Hospice Education Alliance (HEA @ Weldmar) is the provider of internal and external education based within Weldmar Hospicecare Trust. We also lead provision through being the hub for an alliance of End of Life Care Educators across Wessex. In 2015 we delivered End of Life Care education and training to 591 people in the Health Education England working across Wessex foot print.

All programmes have a robust evaluation process and are monitored through a quarterly trust wide education programme group, departmental team meetings and reporting to the Board through the education committee.

The following are selected highlights from our external and internal calendar for 2015:

- We delivered end of life care education and training to 485 people across the region, as the HEA @ Weldmar.
- The HEA @ Weldmar facilitated the GP refresher day, run for the Deanery at Dorset County Hospital: tackling Advance Care Planning (ACP) and difficult conversations, as well as an update on current pharmacological interventions in End of Life Care.
- As the Gold Standards Framework (GSF) Regional Centre we are supporting 12 care homes in phase 11 (2015) and a further 7 in phase 12 (2016) through the programme.
- We have a two phase pilot in progress for the GSF Domiciliary Care Agency programme.
- A series of three train the trainer programmes ran in 2015 to embed the Advance Care Planning work that was undertaken with third sector colleagues; this included our local Partnership for Older People Programme (POPPS) group, Age UK, British Heart Foundation. It gave opportunity to learn how to train and teach their colleagues to start/ have conversations around ACP.
- Within the Trust, in 2015 we had over 95% completion of Training Tracker units (e-based learning) by Weldmar Hospicecare Trust staff at level 1. This was supported with attendance at 92% for additional face to face statutory and mandatory training as indicated by job role and function.
- Our band 4 practitioners have started a Foundation Degree at Weymouth College and complete the Continuous Professional Development (CPD) award section of this in the summer of 2016
- We ran a second programme of our in-house leadership programme for band 6 staff. This had positive evaluation and is being revised for a further programme later in 2016/17
- Support has been given from the HEA @ Weldmar team to the Weldmar central clinical team to cover long term sickness. This has led to greater integration and a day a month allocated to teaching/ clinical input by the HEA @ Weldmar team
- The HEA @ Weldmar team continue to support clinically through active work with many groups including the medicines management group, clinical leadership group, clinical supervisor roles and running the monthly journal club.
- The HEA @ Weldmar meet with the HR team bi-monthly with consideration of workforce planning, performance partnership and Annual Performance Review (APR) processes, and preparatory training for line managers

- A clear taxonomy of learning and development for all staff, clinical and non-clinical at Weldmar Hospicecare Trust, has been agreed at The Trust Board. This will be progressed in 2016
- Funding secured as the Hospice Education Alliance enabled us to support and lead collaborative work with other hospices in the Wessex footprint. These sites are delivering to a further 106 people. We are bringing forward into 2016 a further 209 places from our original bid to develop and run the Qualifications and Credit Framework (QCF) programmes.
- We go into 2016 having secured funding to support a new programme “Ambitions into Actions – shaping the future of End of Life care through education and training”. This programme is aimed at qualified practitioners from all disciplines and is scheduled across the whole of Dorset and Hampshire.

GSF Edcation Session November 2015

3.3 Food Information Regulations

Since the implementation of changes to the Food Information Regulations (2014), largely in relation to the management of allergens the Trust put in place workshops and training sessions. We are able to offer a variety of choices with quality meals made to order for those with both small and large appetites.

3.4 Health and Safety in 15/16

Adverse Incident Reporting (AIRs)

Staff and volunteers are encouraged to complete AIRS if they feel there is a concern regarding health and safety or a threat to quality, as well as when there is an actual incident. This allows Weldmar Hospicecare to be proactive in reducing risk. In response to feedback from staff specific online AIRs training for managers is now available for managers, as well as the generic training. This online training can be used as a tool at any point should a member of staff/ manager require additional support in completing AIRs.

AIRs involving other organisations are reported through the Weldmar online reporting system. Direct liaison takes place with the other organisation as soon as is practicably possible, in order that Weldmar Hospicecare can work in partnership with others to reduce risk. Other monitoring bodies CQC, Dorset Clinical Commissioning Group (DCCG) are involved as appropriate.

Health and Safety Priorities for 15/16

Lone working arrangements

Lone workers have access to a Skyguard device if they are going into a lone worker situation. These simple to use devices are effective in alerting for immediate assistance and are centrally managed so any signal for assistance is picked up by a 24 hour Response Centre. This new system of lone working replaces the sign in/out and buddy system for regular lone workers.

Conflict management

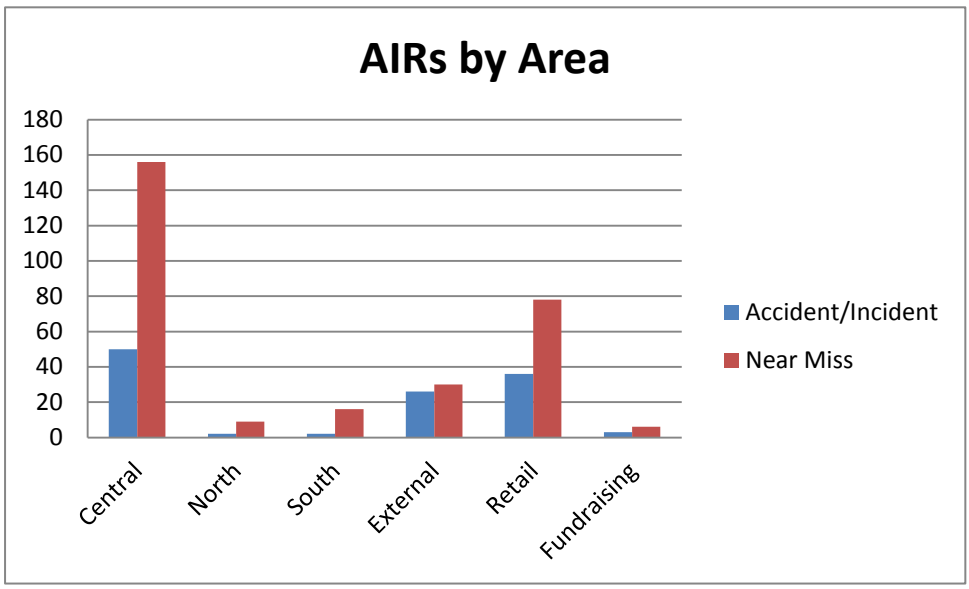
In response to the increasing number of incidents, particularly in the retail sector, online training has been devised which gives practical advice for both prevention and for managing a difficult situation. There are specific modules for different work areas.

Training for volunteers: Moving and Handling, Risk Reporting and Complaints

Patient care volunteers have received specific training regarding moving and handling which includes the moving of a person in an emergency situation, risk reporting, and outlines their role within the complaints management process. As a result of this training AIRs forms for volunteers have the addition of contact numbers - which include an out of office emergency phone number - in order that volunteers can escalate any concerns or changes regarding patients promptly.

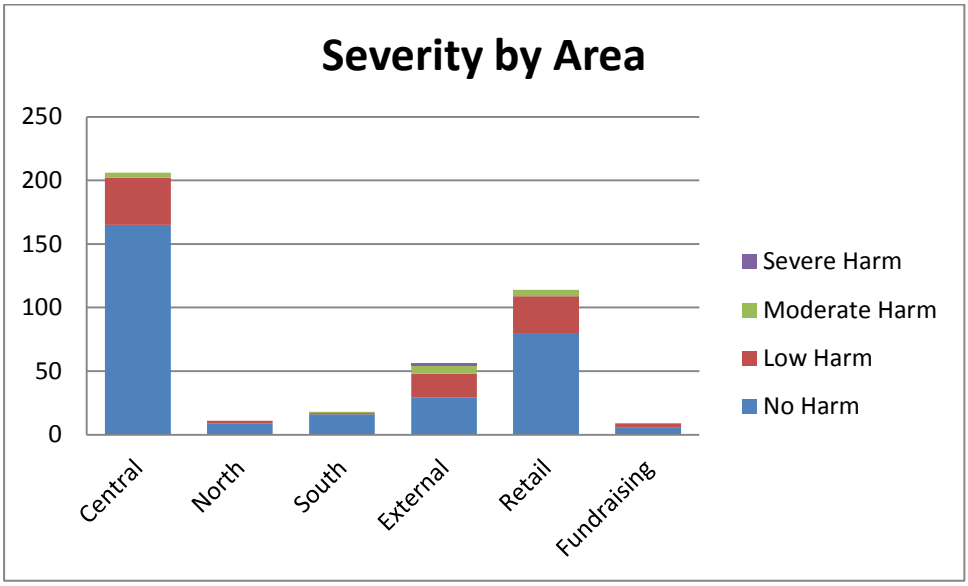
Incident Type by Area 15/16 (12 months)

	Central	North	South	External	Retail	Fundraising
Accident/Incident	50	2	2	26	36	3
Near Miss	156	9	16	30	78	6



Severity of Injury by Area

	Central	North	South	External	Retail	Fundraising
No Harm	165	9	16	29	80	6
Low Harm	37	2	1	19	29	3
Moderate Harm	4	0	1	6	5	0
Severe Harm	0	0	0	2	0	0



No harm – where no harm came to the person *e.g. 'no apparent harm', 'no complaints or pain or visible bruising'*
Low harm - Where the incident resulted in harm that required first aid, minor treatment, extra observation or medication *e.g 'small cut on finger' graze on hand'*

Moderate Harm – Where the harm was likely to require outpatient treatment, admission to hospital or surgery *e.g. sustained fracture to wrist, one inch laceration over eye – taken to A&E for suturing.*
Severe Harm – where permanent harm, such as brain damage or disability, was likely to result *e.g facture neck of femur*

*Definition of the degree of harm as used by **National** Reporting and Learning System (NRLS)*

Details of incidents categorised as Severe or Moderate Harm	**Severe Harm**
2	Pressure sore on admission (grade 4)
	Moderate harm
1	Injury sustained during fit
4	Staff injuries whilst undertaking tasks (taken to hospital) *1
2	Staff injuries whilst undertaking tasks (resulting in a period of absence from work) *1
1	Pressure sore developed during stay at Weldmar (grade 3)
6	Pressure sore on admission (grade 3)
1	Member of the public unwell taken to hospital
1	Volunteer unwell taken to hospital

***Reporting Injuries, Disease and Dangerous Occurrences Regulator (RIDDOR)**

In order to comply with the duty of candour all reportable patient safety incidents were reported to CQC during 2015 and analysed by the Clinical Governance Committee to develop action plans as appropriate.

Health and Safety Priorities for 16/17
- Review of New Online Conflict Training
- Continuing to encourage people to use AIRs
- Review of Risk assessment process in the retail sector

3.5 Patient and Carer Feedback

Complaints: There were 6 complaints over the year (the same as last year). None of the complainants felt it necessary to take the complaint to the Chairman or the Health Ombudsman.

Area of Practice Complaints 2015-16

Quality Requirement	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of complaints received	1	1	1	0	1	0	0	1	0	0	1	0
Percentage of complaints acknowledged within 3 operational days	100 %	100 %	100 %	n/a	100 %	n/a	n/a	100 %	n/a	n/a	100%	n/a
Percentage of complaints responded to within agreed timescales (20 working days)	100 %	100 %	100 %	n/a	100 %	n/a	n/a	100 %	n/a	n/a	100%	n/a
Number of complaints referred to the Ombudsman	0	0	0	n/a	0	0	0	0	0	0	0	0
Date when last complaints summary published on website	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15	Feb-15

Details of lesson learnt and actions taken

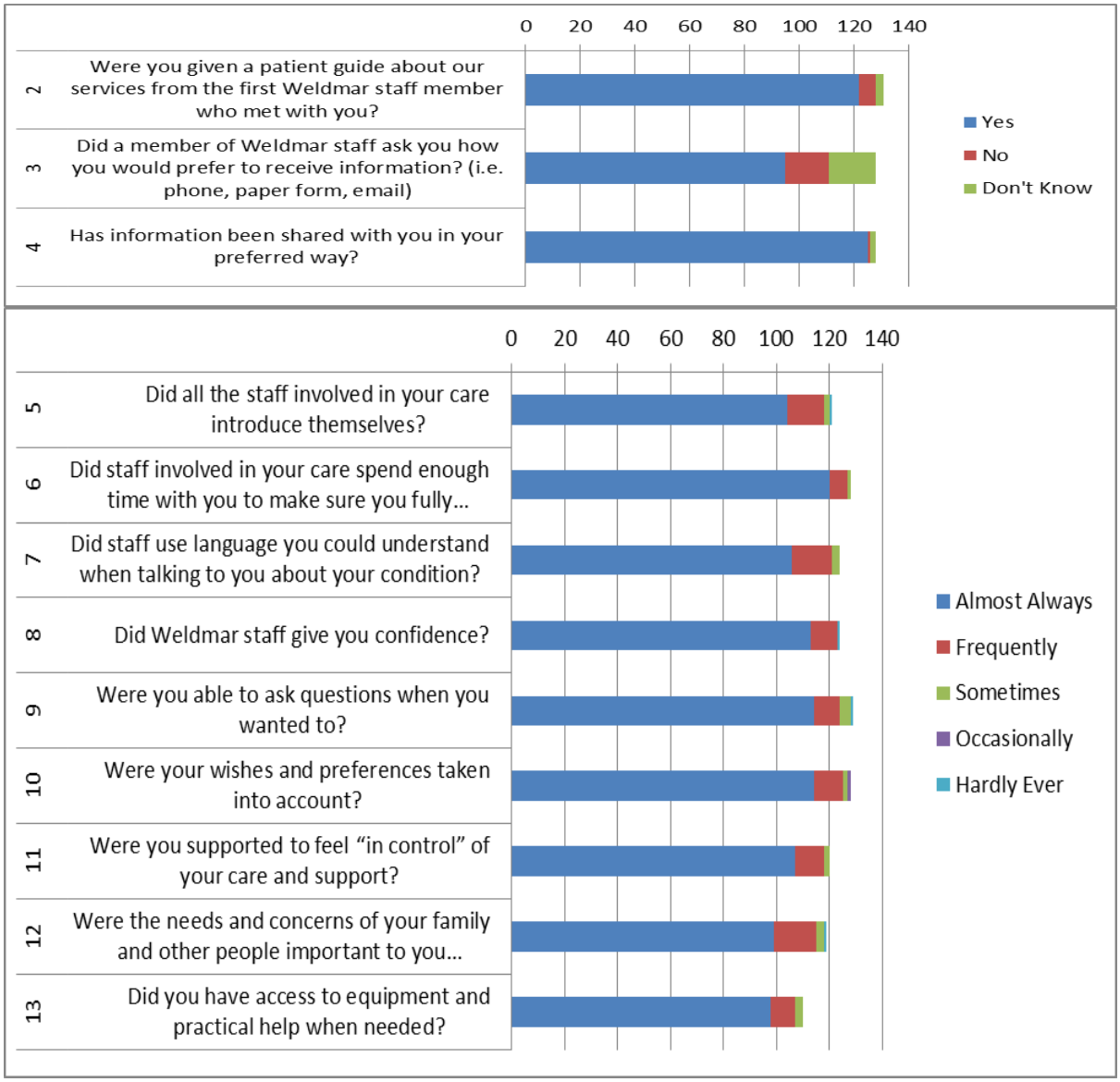
	Issue	Action
1	Wife thought she had been coerced into having her husband discharged home. (Her husband wanted to go home to die.) Did not want to make the necessary changes to her house to allow for a hospital bed	Be clearer with families why we need to have discharge discussions with families in order to cater for patients' wishes.
2	We had sent a letter to a house with the keycode on the envelope	Reviewed admin. systems to ensure this does not happen again
3	Delay in completing a form for care at home. Staff member needed evidence and this took time	Keep the person informed when there are delays
4	Communication issues. Promising contact, but not making it and relying on someone else to instead. Contact also when at home, lacking	Ensure we always contact when we say we will. Clarify the best way of communicating with someone with the individual. Discuss with the hospital team for seam free care.
5	Relative felt she had to be a nurse, not a daughter in the last weeks of her mother's life. No care available and little respite. Too little too late. Complex situation with many agencies involved.	On going issue getting care in the community. Funding available, but no care. Pilot a 24/7 advice line (done) and rapid response. Better respite care required and consideration of respite for patients with dementia.
6	Complex case where relative felt the morphine being prescribed was causing the symptoms. Relationship with one of our Drs	Unfortunately, this was a misunderstanding of the medical condition, cause and effect. Explained to the complainant.

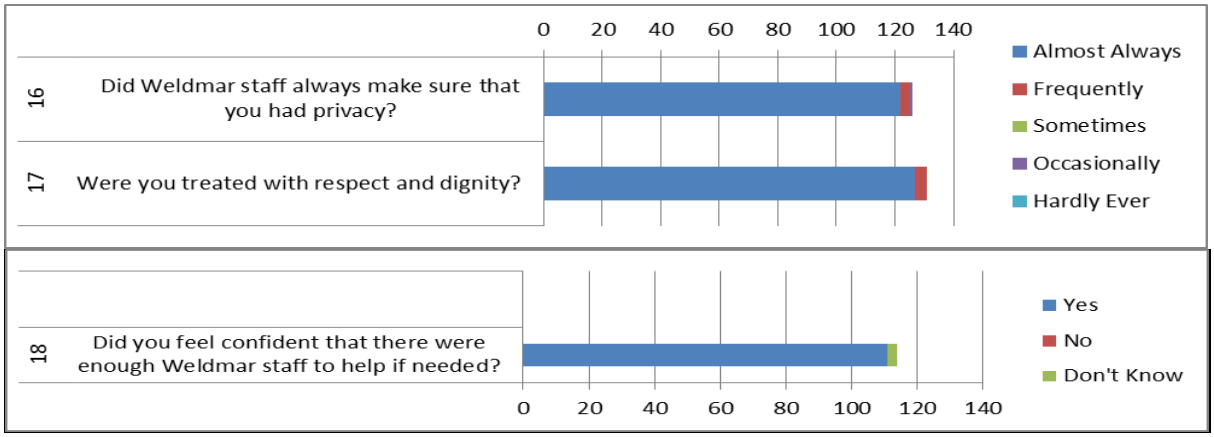
Summary

Two complaints came from the IPU, three from the community and one about mail received from us. Poor or inadequate communication is often at the root of the problem. Sometimes patients and relatives find it difficult to accept what is being said to them and this can lead to misunderstanding. We continually strive to improve communication skills throughout the Trust. The lack of clinical nursing leadership (unable to appoint) in our central area has contributed to a high level of sickness in one area of the community. This will be addressed by reviewing the idea of developing a training centre for the Trust, where clinical staff of all levels can be taught and mentored before working alone in the community. We must be able to 'grow our own' staff, as we look to the future of increasing workloads and a decreasing number of people in the care profession.

Surveys and Reflections

Below is the table showing responses to the Patient Experience Questionnaire for 2015-16





Lambs visit patients at Weldmar

Reflections

These forms are available throughout the Trust for anyone to reflect positively or negatively on any element of the service. During 2015/16 WHT received a total of **94** Reflection Forms commenting on various areas of the Trust's services.

Comments on different parts of the service:

- 24 x Carer Support, Chaplaincy, Bereavement Support
- 14 x Complementary Therapies
- 15 x InPatient Unit
- 13 x Day Hospice/Social Group
- 6 x Remembrance Services
- 8 x Children's event/support
- 6 x Other (including maintenance & education)
- 4 x Community Nurse
- 1 x Volunteer Services
- 3 x Catering/Hotel Services

The forms were completed by the following:

- 30 x Bereaved Relative
- 21 x Carer
- 13 x Patients
- 12 x Anonymous
- 10 x Staff
- 6 x Healthcare Professionals
- 2 x Volunteer

All of the comments received were shared with individual members of staff (where named) and /or departments immediately upon receipt. Overwhelmingly the majority of feedback received has been positive, praiseworthy and complementary indicating a very high level of satisfaction with a wide range of services provided across the Trust.

A small number of comments made prompted us to reflect upon and give consideration to how we deliver our services.

Children's Bereavement Event Easter 2016

3.6 Improved Documentation

Much has been achieved in this area this year, in streamlining documentation, making our electronic tools fit for purpose and more accurate for reporting purposes, and ensuring the cycle is complete.

- Clinical Records Monitoring Group (CRMG) meet bi-monthly to audit randomly selected set of records against the Clinical Recording Standards. The group have been looking at the consistency and quality of data sourced from our electronic patient record system (Crosscare) to see how they correspond with agreed national standards. These standards have been set against a backdrop of national guidelines linked to the requirements of the main professional bodies (the General Medical Council, Nursing and Midwifery Council and Health Professionals Council).This group has found it a very useful exercise. Whilst identifying some inconsistencies and putting in place a training process for improvement they have been heartened by the clear improvement in quality. This work is under the umbrella of the Clinical Documentation Group (CDG), as part of the clinical governance structure. The membership is a peer group only which seems to work very well and feeds into the Mentoring group, see below. Improvement and development work is delivered via two main sub-groups – the Clinical Records Monitoring Group (CRMG) and the Clinical Data Quality Group (CDQG).

- A third group of Crosscare Mentors has been established to support training and communication needs of Crosscare users across the Trust. The approach is one of motivating and empowering users to achieve clear standards.

A continuous review of windows on Crosscare has been undertaken to reduce duplication and simplify the process as well as enhancing reporting processes. As an outcome:

- documentation of the assessment of patients' needs is comprehensive and streamlined
- increased user satisfaction with the revised system
- increased efficiency of time taken for documenting the assessment has been reduced from forty five to twenty minutes.
- A new management plan window enables any member of the clinical team to rapidly review the overall plan for the patients. This is particularly useful for on call team members who may not know the patient well but may be requested to undertake urgent review.

Joseph Weld Hospice

4. Priorities for improvement 2016/17

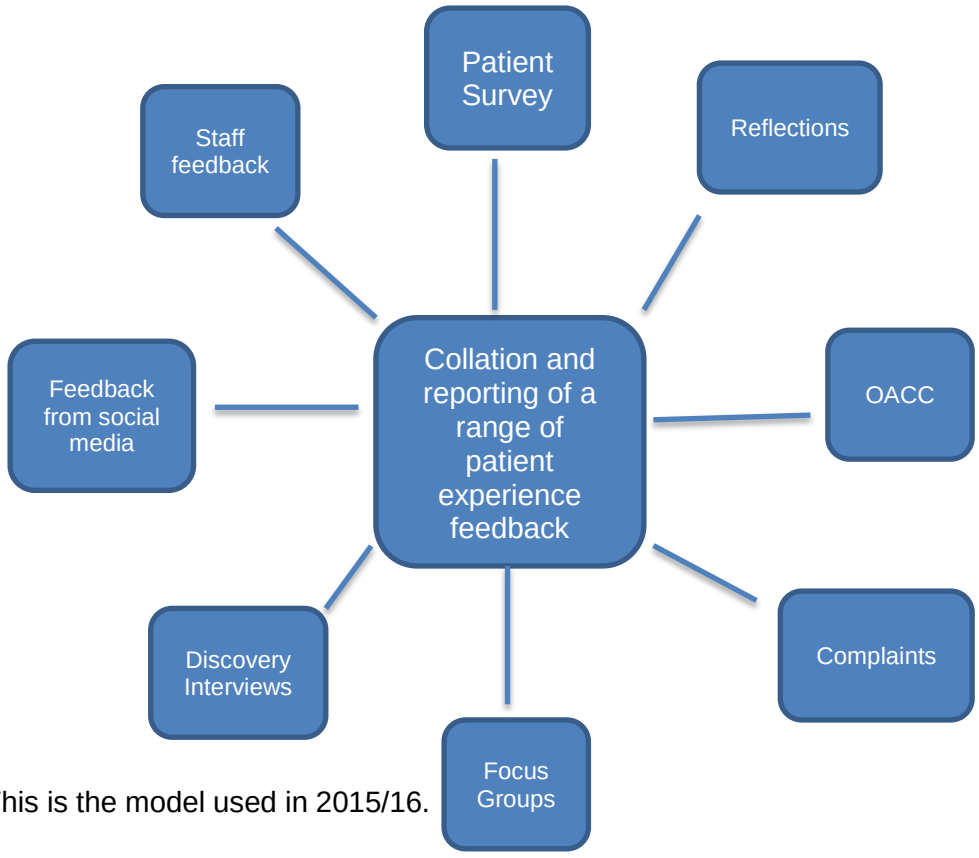
4.1 Improved Quality of Feedback from Patients and Carers

Because: Hospice services have struggled over the years to get feedback from patients and carers about the care they want and the efficacy of the care they actually receive. This has been difficult because most tools have concentrated on only one part of patient care, e.g. symptom relief, and therefore are not holistic. We constantly receive many very positive comments, which, although gratifying, do not help us improve care and services in a patient driven way.

Covering: Direct feedback from patients and carers through a new validated system from King's College, Outcome Assessment and Complexity Collaborative (OACC)[2] health services and health care professionals are required to demonstrate that they meet the needs of individual patients and their families, and that they do this in an effective and efficient way from the patient and carer's point of view. This suite of measures can be used to improve team working, drive quality improvement, deliver evidence on the impact of services, inform commissioning and, most importantly, achieve better results for patients and families. We also intend to introduce other ways of measuring satisfaction such as Discovery Interviews, which are quality based interviews with families of deceased patients.

Desired Outcomes: Being able to deliver more patient centred and led, responsive care and services to patients and their families.

Ongoing Actions 2016/17: Develop 'you said we did' reporting to feedback on comments and complaints.



This is the model used in 2015/16.

[2] OACC Outcome Assessment and Complexity Collaborative, launched in 2013 Dr Fliss Murtagh and team Kings College, London, Cicely Saunders Institute and Partners.

4.2. Reporting and action on Equality and Diversity

Being aware that we are not good enough at recording and gathering equality and diversity information and not reaching areas such as: prisons, ethnic minorities, homeless etc

Desired Outcomes: Better recording, more awareness and analysis of areas we are not reaching and a plan to reach them**.**

What we did:

- We have continued to encourage recording of all protected characteristics on our patient recording system. During the year there has been some improvement in the completeness of this data in relation to the protected characteristics of sexual orientation, religion or belief and race.
- We have requested an amendment to the patient recording system by the developers to enable the protected characteristic of disability to be specifically recorded – this has been promised but release date for the software update is not yet confirmed.
- Protected characteristics data collected from staff, patients and volunteers is compared with the same data for the local population to ensure our service provision and delivery is meeting the needs of our local population.
- A Web links document has been added to the Education and Development (E & D) Intranet page providing information for staff detailing local support services related to some of the priority groups identified – such as ethnic minorities, travellers, LGBT, homeless, people with disabilities.
- Introduced Hospice UK Action Plan – working towards equality and diversity.

Ongoing actions 2016/17:

- Continued commitment to improvement of patient recording of protected characteristics.
- Development of links with local groups working with people most likely to be underrepresented in our service provision, including travellers, people living with dementia or people with learning disabilities.
- Implementing actions identified in the Hospice UK Action Plan.
- Consideration of the requirements of the Accessible Information Standard.

4.3 Rapid Response/24 hour service

Because things can go wrong at home, usually out of hours, services are not fast to respond and may respond inappropriately by admitting someone to hospital, who dies shortly afterwards. People want to stay at home as long as possible, sometimes some reassurance on the phone is all they need, or someone to sit with the patient while a carer gets some much needed rest. The pilot covered Dorchester and Weymouth in the first instance.

Desired Outcomes: Learn whether a 24/7 service is needed.

What happened:
The pilot ran from 5 October to 14 December 2015. During this time 177 calls were received (patients 40, Carers 100 and other health care professionals 37). Interestingly most calls were in the morning, and few at night.

Day of week

Monday	31
Tuesday	15
Wednesday	22
Thursday	17
Friday	28
Saturday	35
Sunday	57

Call handler

IPU Nurse	136
Weldmar Community Nurse	91
Weldmar Doctor	1

Primary reason for call

Symptom & Medication advice	86
Issues with care or carers	24
Issues with pt transport	2
Bmt advice & support	9
Request for WCN visit	15
General follow up	44

Primary Outcome

Call to 111	25
Call to 999	3
Contact with DN	27
Contact with GP	9
Call to patient transport services	4
Return call to carer/pt	27
Liaise with WHT doctor	11
Other WHT prof	11
WCN	65

Carer felt 24/7 call had indeed been helpful/reassuring in placing patient in a safe environment, preventing emergency admission to hospital setting which patient did not want. She knew GP who had called to house and felt this helped. She felt call was personal and reassured by alleviating 'her worst nightmare'

Questions to staff and some feedback:

What do you consider the main benefits of this service for patients and carers?

- Reassurance at the end of a phone, comforting to know there is always someone there to help. May prevent symptoms escalating, or issues escalating to an emergency.

- help and advice, security for patient and carers
- point of access for information for patients and carers, this service is beneficial as they may feel isolated, frightened or worried in certain situations
- Patients and carers are able to speak to a person quickly and not get an automated service are referred on to make another telephone call. Their issue will be resolved or they will be assisted and reassured in a timely manner
- Having a voice to talk to.
- It provides a personal service of reassurance
- Callers I have spoken with have commented they have been comforted by (a) being able to speak to someone (b) speaking to someone immediately, even if I haven't been able to give advice other than signposting.

Ongoing Actions 2016/17
This was a successful pilot, able to reach many people and prevent inappropriate admissions to hospital. The service was run mostly by the IPU and community nurses. This had an impact on the nurses' time during their shifts on the IPU and the resources of a permanent service needs to be carefully considered.
Next steps are to investigate and, if financially viable, develop and deliver a 24/7 helpline service.

4.4 Refurbishment of Hospice

During 2016/17 it is planned to refurbish areas of the hospice to enhance the environment for patients and their families, including dementia patients.

4.5 Increasing numbers in the MND Clinic

The hospice has successfully run an MND clinic, in partnership with the NHS hospital in Poole, at Joseph Weld Hospice for many years. It is however becoming a victim of its own success and during 2016/17 plans will be developed to extend this service if financially viable.

5. Staff

Recruitment and Sickness Absence 15/16

Recruitment
This report covers the twelve months ending 31st March 2016 and analyses the numbers of joiners and leavers for the period. The total number of full and part time permanent staff employed at 31st March 2016 was 227 .There were 42 joiners and 29 leavers during the twelve months, giving an annualised staff turnover rate of 12.78%. For comparative purposes, the staff turnover rate for 2014/15 was 12.32%.
A breakdown of the above data is shown below.

Staff Group	Staff Numbers	Joiners	Leavers	Staff Turnover
Clinical Staff	90	9	8	8.89%
Retail Staff	68	20	13	19.12%
Hotel Services	16	3	3	18.75%
Admin/Mgt.	53	10	5	9.43%
Total Trust	**227**	**42**	**29**	**12.78%**

Sickness Absence
The sickness/absence rate for the twelve months ending 31st March 2016 was 4.37% (% hours lost against contracted hours). If long term sickness/absence is excluded, the rate falls to 2.78%. We currently have 8 members of staff away long term sick.

For comparative purposes, the sickness/absence rate for 2014/15 was 5.07%, falling to 2.80% if long term sickness/absence is excluded.

Disciplinary and Dismissal Procedures
During the twelve months under review, the following action was taken under the Disciplinary and Dismissal Procedures:

1 Written warning.
1 Final written warning.
2 Dismissals.
2 Redundancy dismissals.

There was no evidence of discriminatory practice identified in the operation of the Disciplinary or Dismissal Procedures.

Grievance Procedure
During the twelve months under review, the Grievance Procedure was invoked on 3 occasions. There was no evidence of discriminatory practice.

Whistleblowing Policy
No member of staff invoked the Whistleblowing Policy during the period under review.

2015 Employee Satisfaction Survey Results

Summary
This year's results are again pleasing and help to consolidate the significant improvements which were achieved in response to many of last year's questions. This year 115 questionnaires were completed - a response rate of 54.25%. Last year's response rate was 54.15%, (almost identical with the previous year). 70 questionnaires were completed on line (40 last year) and 45 completed in hard copy. Highlights from this year's results are as follows. All percentage figures shown indicate strongly agree/agree.

There were some questions where one or another department had a markedly lower score from the Trust average and these were marked with *. The issues are being taken up by the CEO with the relevant Director(s):
Questions 1-5: I understand the Hospice Strategy **(96%);** My department works towards clear goals **(91%);** I am kept informed of changes **(83%);** I am involved in decisions affecting my work **(80%);** There is good teamwork in my department **(83%)**
Questions 8-12: I have confidence in the effectiveness of my line manager **(88%);** I am given regular feedback by my line manager **(92%);** I am treated fairly by my line manager **(92%);** I have regular 1:1 meetings with my line manager **(93%);** My performance has been appraised accurately **(95%);**
Questions 13&14: I am encouraged to develop my skills **(89%);** I have significantly enhanced my skills over the last year **(79%).**
Questions 15&16: I am given the opportunity to express my views **(87%);** I am encouraged to contribute ideas within my dept. **(88%).**
Question 17: I am rewarded fairly with pay and conditions for the work I do **(76%).**

Questions 20&21: My line manager shows a sincere interest in my career and provides me with the support I need **(89%);** I am adequately supported in coping with the stresses of the job **(84%).**
Question 22: Organisation systems and procedures are clearly defined **(84%).**
Question 26: I feel respected and appreciated at Weldmar **(81%).**
Question 27: I feel able to give honest feedback to management **(75%).**
Question 28: Overall I am satisfied with my job **(92%).**
Question 29: I am satisfied with my work/life balance **(80%)**
Question 30: I do what I am best at every day **(89%).**

Responses which expressed concern were:

Question 6: Communication throughout Weldmar is regular and effective **(61%).**
Question 18: Staff are considered to be the Trust's most important asset. **(61%).**
Question 19: Staffing levels are adequate for the workload **(53%)*.**
Question 23: I believe management will take action as a result of this survey **(64%).**
Questions 24&25: Morale in my department is satisfactory **(65%).** Morale throughout the organisation is satisfactory **(53%).**
Question 7: The responses to this question were corrupted in transferring across to SQL.

Action taken in response to last year's questionnaire survey was as follows:

- Move the online questionnaire from the website to the intranet for ease of completion.
- Set an earlier deadline to encourage the completion of questionnaires.
- Introduce the Performance Partnership Scheme, in particular regular 1:1 meetings with line managers, in order to listen to staff, involve staff in decision making, and improve the performance management of the organisation as a whole.

6. Volunteer Activity

1 April 2015 to 31 March 2016

Patient Care Volunteer Activity

	Tasks Undertaken	Hours Worked	(average)
Community:			
Admin duties (incl Finance, governance groups, office support)	470	1,410	2-3 hrs
Befriending	5	360	3 hrs for 24 weeks
Carers' Support Group	19	38	2 hrs
Chaplaincy (incl events / services)	32	58	1-3 hrs
Collecting prescriptions	9	9	1 hr
Companion	3	216	3 hrs for 24 weeks
Complementary Therapy (qualified practitioners)	34	204	1 hr for 6 wks
Family Support (emotional support)	82	82	1 hr
Gardening	1	3	3 hrs
HH Reception	198	396	2 hrs
Jam Che Bereavement Coffee Morning	7	14	2 hrs
Jam Che (Gentle Touch) including Hammick House	5	15	1 hr for 3 wks

Refreshments	4	8	2 hrs
Sitting	9	432	2 hrs for 24 wks
Social Group	395	1,580	4 hrs
Social Group Transport (own car)	177	354	2 hrs
Transport (own car)	59	118	2 hrs
Wellbeing Centres:			
Arts Therapy	42	42	1 hr
Chaplaincy	27	54	2 hrs
Creative Therapy	98	196	2 hrs
Daycare Help	179	537	3 hrs
Hair Dressing	120	240	2 hrs
Hotel Services	20	80	4 hrs
Jam Che (Gentle Touch)	160	320	2 hrs
Meal Assistant (feeding)	11	11	1 hr
Minibus	86	172	2 hrs
Reception (John Greener)	52	104	2 hrs
Recreational	12	48	4 hrs
Transport (own car)	64	128	2 hrs
In-Patient Unit:			
Chaplaincy	52	156	3 hrs
Family Support (qualified counsellors & coffee mornings / events)	210	278	1-3 hrs
Flower Arranging	250	500	2 hrs
Handyman & Gardening	66	132	2 hrs
Hotel Services	106	218	2-4 hrs
Jam Che (Gentle Touch)	118	236	2 hrs
Meal Assistant (feeding)	6	6	1 hr
Pets As Therapy	76	76	1 hr
Reception	811	2,433	3 hrs
Sitting	6	12	2 hrs
Ward	623	1,246	2 hrs
Totals	**4,704**	**12,522**	

Thanking our volunteers during Volunteers' Week 2015

7. Information Governance

IG Toolkit Version 13 (2015-2016) Assessment

Req No	Description	Status	Attainment Level
Information Governance Management			
13-101	There is an adequate Information Governance Management Framework to support the current and evolving Information Governance agenda	Reviewed And Updated	Level 3
13-105	There are approved and comprehensive Information Governance Policies with associated strategies and/or improvement plans	Reviewed And Updated	Level 3
13-110	Formal contractual arrangements that include compliance with information governance requirements, are in place with all contractors and support organisations	Reviewed And Updated	Level 3
13-111	Employment contracts which include compliance with information governance standards are in place for all individuals carrying out work on behalf of the organisation	Reviewed And Updated	Level 3
13-112	Information Governance awareness and mandatory training procedures are in place and all staff are appropriately trained	Reviewed And Updated	Level 3
Confidentiality and Data Protection Assurance			
13-200	The Information Governance agenda is supported by adequate confidentiality and data protection skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Updated	Level 3
13-201	The organisation ensures that arrangements are in place to support and promote information sharing for coordinated and integrated care, and staff are provided with clear guidance on sharing information for care in an effective, secure and safe manner	Reviewed And Updated	Level 3
13-202	Confidential personal information is only shared and used in a lawful manner and objections to the disclosure or use of this information are appropriately respected	Reviewed And Updated	Level 3
13-203	Patients, service users and the public understand how personal information is used and shared for both direct and non-direct care, and are fully informed of their rights in relation to such use	Reviewed And Updated	Level 3
13-205	There are appropriate procedures for recognising and responding to individuals' requests for access to their personal data	Reviewed And Updated	Level 2
13-206	Staff access to confidential personal information is monitored and audited. Where care records are held electronically, audit trail details about access to a record can be made available to the individual concerned on request	Reviewed And Updated	Level 3
13-209	All person identifiable data processed outside of the UK complies with the Data Protection Act 1998 and Department of Health guidelines	Answered	Not Relevant
13-210	All new processes, services, information systems, and other relevant information assets are developed and implemented in a secure and structured manner, and comply with IG security accreditation,	Reviewed And Updated	Level 3

	information quality and confidentiality and data protection requirements		
Information Security Assurance			
13-300	The Information Governance agenda is supported by adequate information security skills, knowledge and experience which meet the organisation's assessed needs	Reviewed And Updated	Level 3
13-301	A formal information security risk assessment and management programme for key Information Assets has been documented, implemented and reviewed	Reviewed And Updated	Level 2
13-302	There are documented information security incident / event reporting and management procedures that are accessible to all staff	Reviewed And Updated	Level 3
13-303	There are established business processes and procedures that satisfy the organisation's obligations as a Registration Authority	Answered	Not Relevant
13-304	Monitoring and enforcement processes are in place to ensure NHS national application Smartcard users comply with the terms and conditions of use	Reviewed And Updated	Level 2
13-305	Operating and application information systems (under the organisation's control) support appropriate access control functionality and documented and managed access rights are in place for all users of these systems	Reviewed And Updated	Level 3
13-307	An effectively supported Senior Information Risk Owner takes ownership of the organisation's information risk policy and information risk management strategy	Reviewed And Updated	Level 3
13-308	All transfers of hardcopy and digital person identifiable and sensitive information have been identified, mapped and risk assessed; technical and organisational measures adequately secure these transfers	Reviewed And Updated	Level 2
13-309	Business continuity plans are up to date and tested for all critical information assets (data processing facilities, communications services and data) and service - specific measures are in place	Reviewed And Updated	Level 3
13-313	Policy and procedures are in place to ensure that Information Communication Technology (ICT) networks operate securely	Reviewed And Updated	Level 3
13-314	Policy and procedures ensure that mobile computing and teleworking are secure	Reviewed And Updated	Level 3
13-323	All information assets that hold, or are, personal data are protected by appropriate organisational and technical measures	Reviewed And Updated	Level 3
13-324	The confidentiality of service user information is protected through use of pseudonymisation and anonymisation techniques where appropriate	Reviewed And Updated	Level 3
Clinical Information Assurance			
13-400	The Information Governance agenda is supported by adequate information quality and records management skills, knowledge and experience	Reviewed And Updated	Level 3
13-401	There is consistent and comprehensive use of the NHS Number in line with National Patient Safety Agency requirements	Reviewed And Updated	Level 3

13-402	Procedures are in place to ensure the accuracy of service user information on all systems and /or records that support the provision of care	Reviewed And Updated	Level 3 

8. Statutory Assurance From The Board

The following are statements that all providers must include in their Quality Account. Many of these statements are not directly applicable to specialist palliative care providers, and therefore explanations of what these statements mean are also given.

Review of Services

During 2015/16 Weldmar Hospicecare Trust provided the following services to the NHS:

- Inpatient Unit – 4 beds
- Day Hospice
- Community Specialist Palliative Care service
- Occupational Therapy, Physiotherapy,
- Complementary and Creative Therapies
- Family, Carer and Psychological Support Services, including bereavement support

The quality of these services, which represent some 30% of the patient care given by Weldmar Hospicecare Trust, has been reviewed and is covered by these Quality Accounts.

What this means:

Weldmar Hospicecare Trust is partly funded through an NHS contract linked to activity through a Community Contract for 2015 -2016. The funding allocated by NHS Dorset CCG represents approximately 25% of the Trust's total income (30% of clinical costs). The remaining income is generated through fundraising, shops, lottery activity and investments.

Participation in National Clinical Audit

- During 2015/16 no national clinical audits or confidential enquiries covered NHS services provided by Weldmar Hospicecare Trust
- During the period Weldmar Hospicecare Trust participated in no (0%) national clinical audits and no (0%) confidential enquiries of the national clinical audits and national confidential enquiries it was eligible to participate in.
- The national clinical audits and national confidential enquiries that Weldmar Hospicecare Trust was eligible to participate in during 2015/16 are as follows: NONE
- The national clinical audits and national confidential enquiries that Weldmar Hospicecare Trust participated in during 2015/16 are as follows: NONE
- The national clinical audits and national confidential enquiries that Weldmar Hospicecare Trust participated in and for which data collection was completed during 2015/16 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. NONE
- Weldmar Hospicecare Trust was not eligible in 2015/16 to participate in any national clinical audits or national confidential enquiries and therefore there is no information to submit.
- The number of patients receiving relevant health services provided or sub-contracted by Weldmar Hospicecare Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee: NONE
- A proportion of Weldmar Hospicecare Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed between Weldmar Hospicecare Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically via www.weld-hospice.org.uk

- Weldmar Hospicecare Trust has not participated in any special reviews or investigations by the CQC during the reporting period.
- Weldmar Hospicecare Trust did not submit records during 2015/16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data as we are not eligible to submit to this system.
- Weldmar Hospicecare Trust Information Governance Assessment Report overall score for 2015/16 was as detailed in Section 7 above.
- Weldmar Hospicecare Trust was not subject to the Payment by Results clinical coding audit during 2015/16 by the Audit Commission.

What this means:
As a provider of specialist palliative care Weldmar Hospicecare Trust is not eligible to participate in any of the national clinical audits or national confidential enquiries. This is because none of the 2015/16 audits or enquiries related to specialist palliative care.

The Hospice will also not be eligible to take part in any national audit or confidential enquiry in 2016/17 for the same reason.

9. Statement from the Care Quality Commission

Weldmar Hospicecare Trust is required to register with the Care Quality Commission and its current registration status is Independent Hospital, Hospice for Adults. Weldmar Hospicecare Trust has the following conditions on registration:

- The service may only be provided for persons aged 18 years or over
- A maximum of 18 patients may only be accommodated overnight
- Notification in writing must be provided to the Care Quality Commission at least one month prior to providing treatment or services not detailed in our Statement of Purpose

Weldmar Hospicecare Trust is subject to periodic reviews by the Care Quality Commission (CQC) A CQC inspection of Weldmar Hospicecare was carried out in March 2016 and a grading of 'Outstanding' was given.

10. CQC Ratings Grid

Ratings	
Overall rating for this service	Outstanding ☆
Is the service safe?	Good ●
Is the service effective?	Outstanding ☆
Is the service caring?	Outstanding ☆
Is the service responsive?	Outstanding ☆
Is the service well-led?	Good ●

11. Statement from NHS Dorset

“Over the past year Weldmar has striven to maintain its focus on improving the quality of care provided to individuals. The report outlines the range of quality improvement work and training that has been undertaken over the last year. This has been reflected in the CQC “outstanding” rating that was recently awarded to the Trust. The key priorities identified for 2015/16 have also shown improvement. In particular the development of the wellbeing strategy and services; designed to be more flexible to meet individual’s needs. There has also been extensive training provided by the Trust across Wessex and increased responsiveness to health and safety issues for staff and volunteers. Feedback from patients and carers continues to be a key priority for the Trust and this is reflected within the quality account.

The CCG has not been actively engaged in the development of the Quality Improvement Priorities that the organisation has set for 2016/17 but is in broad support of these priorities and looks forward to working with Weldmar during the year.”

Day Trip from Trimar on MV Freedom round Weymouth Bay

Appendix 1

The National Council for Palliative Care – Minimum Data Sets

	2015/16	2014/15	2013/14	2012/13	2011/12	2010/11
Inpatient Unit						
Total number of patients	174	202*	218	241	236	199
New patients	162	176	191	211	208	178
% Occupancy	61.1%	73.68%	72.8%	80.5%	71.6%	79.9%
% returning home	36%	40.1%	30.3%	35.7%	34.1%	31.4%
Average LOS	15.6	14.8 days	15.9 days	14.2 days	12.9 days	16.2 days
Day Hospice						
Total number of patients	97	123	139	136	125	99
Sessions held	231	254	310	302	364	349
Attendances	1753	1623	1961	2205	2011	1844
Average length of care	201.4	181.6 days	243.5 days	225 days	239.6 days	189.5 days
Community Service						
Total number of patients	1020	1008	988	976	970	970
Total contacts face to face	No longer in MDS	7972	8474	4850	5698	5904
Total contacts telephone	No longer in MDS	12372	11150	10219	10242	10789
Average length of care	130.4	109 days	99.7 days	95.2 days	90.4 days	101.5 days
Family support						
Total number of clients	170	189	193	181	298	382
Total contacts	1172	1355	1204	1034	1804	1693
Average length of care	283.1	248.2 days	215.8 days	159.7 days	133.2 days	127.2 days
Outpatients	103	72	151	149	144	145

- A correction has been made to the 2014/15 total number of patients due to the total number of admissions reported in error

Appendix 2

Results of 15/16 Audits

Falls, medication errors and pressure sores	Benchmarking nationally and with the south west. Our documentation and AIRs reporting of all these areas has improved after our Practice Improvement Project on the In Patient Unit. We benchmark well with other hospices with regards to falls although slightly higher with pressure ulcers and considerably higher with medication errors. However, it has now been agreed that Medication Incidents will only be reported to HUK if they have reached the patient as this is the definition used by participating units and therefore these figures should reduce considerably. All medication incidents will continue to be recorded internally regardless of whether they reach the patient or not and monitored monthly by MMG.
Accountable Officer	• Documentation now being created to evidence changes to the appointment of the CDAO. • AO report to be included on the quarterly CGC agenda. • Medication to be prescribed by drug, not brand. If brand is important this to be added in brackets. • Prescribing audit to be completed.
Controlled Drugs	• Approved signatories' (including doctors) list now up to date. • All nurses have been reminded that corrections in CDRs should be signed and dated. • Doctors have been reminded that prescriptions should not be altered or additions made (they should be re-written). • The name of the Nurse and name of witness are documented in destruction book (not initials) and are signed by both.
Dorset Network Audit on face to face contact with patients	• Some months have shown a higher percentage of delays although this was due to lower staffing levels. No patients came to any harm from this delay. • Documentation improved.
Prescription Pad Security	• To be included in the Medicines Management policy. Information displayed in Sisters communication book. PharmacyFax bulletin highlighting security requirements displayed prominently on the Controlled Drug cupboard door. • Sister ensures all information is recorded. Due to low usage, a weekly audit is carried out. • Sister has compiled a list of practitioners authorised to prescribe on their FP10s. • Trained nursing staff record destruction of drugs.
Discharge Planning	Eight patients had delayed discharges totalling 253 days: o Family unable to cope with patient at home due to patient's dementia and also increased care need. Standard CHC application submitted and approved. o Admitted originally for EOLC but not at end of life. Patient declined to engage in discharge discussions and also refused to sign consent form for 4 days and had capacity to do so. Delayed allocation to Social Worker despite numerous phone calls and letter from Dr. No reply to letter. RIP on IPU. o Admitted for symptom control. Had fast track funding on admission. Patient's condition was varied. Unable to find suitable nursing home. Decided at MDT meeting that due to patient's deteriorating condition patient to remain at JWH for EOLC. o CHC in place but unable to find care. o Re-ablement support in place but unable to commence on discharge date.

	○ CHC in place prior to admission. Discharge planned to care home. Wife decided she would like patient to be at home instead. Discharge due to family delays. Discharged home with live in carer. ○ Standard CHC application completed and approved 11 days later. Patient decided on a suitable Nursing Home and was then discharged. ○ Admitted originally for EOLC but not EOL on admission. Already known to Social services (SS). IMCA had to be involved as patient lacks capacity. For a number of weeks unable to find 24/7 care and were still awaiting brokerage search results. Letter from Dr regarding delays in discharge. Assessed by care agency and costings for care finally agreed for 24/7 care, QDS double up care and night care. Funding declined for care at home and Nursing Home placement agreed.

Infection Control Audits Actions 15/16

Bed and Mattresses Mattresses numbered 1 Mattress cover found to be beginning to become unusable. All beds clean and in good working order.	• Now easily identified • One on order to replace.
Catheters Only one concern in 2015 that one patient had a sample sent off, nothing was grown however the patient continued on antibiotics. Insertion remains for rationalised reasons	• This had only occurred once since catheter audit has commenced in May 2012 (4 years) • Continue to observe
Decontamination All areas clean at time of audit minimal items were dusty	• Audit findings shared with nursing staff and hotel services.
Sharps Temporary closure: not closed Needle safe integral part of nursing culture.	• Added to teaching sessions, and reiterated in training sessions
Commodes Commode underside always cleaned effectively Foot plates not cleaned to correct standard	• Storing cleaned commode with seat upside down is being effective. • Reminding all staff of cleaning foot plates as well as all of commode
Hand hygiene North 92% compliance South 88% compliance Central 96% compliance	• No hand cream available, this is a hospital that the well-being centre is based, have emailed the lead this is a minimal issue. No hand poster in place, this has been rectified. • No hand gels in place, this has now been rectified. Hand cream not available in all rooms. Is available in one central point. • 1 Fit bit in place when checked. Asked to remove at time of audit, have not observed it since.

Appendix 3
CCG Contract Monitoring Requirements 2015-16

Area of Practice	Quality Requirement	Threshold
Risk Assessments and Screening	% of Falls assessments completed within 24hrs of admission	95% + = Green 90 -94% = Amber Under 90% = Red
	% of Nutrition assessments completed within 24hrs of admission	
	% of Pressure Ulcer assessments completed within 6hrs of admission	
Infection Control	Percentage of patients screened for MRSA	
	MRSA Bacteraemia	0=Green 1 or above=Red
	Clostridium Difficile	
	MSSA	
	E-coli	
	Norovirus	
Pressure Ulcers	Number of all provider acquired Pressure Ulcers	
	Number of all provider inherited Pressure ulcers	
Medication Errors	No Harm (Level 0)	
	No Harm (Level 1)	
	Low Harm (Level 2)	
	Moderate Harm (Level 3)	
	Severe Harm (Level 4)	
	Death (Level 5)	
	Number of medication errors relating to controlled drugs	
Falls	No Harm (Level 1)	
	Low Harm (Level 2)	
	Moderate Harm (Level 3)	
	Severe Harm (Level 4)	
	Death (Level 5)	
Incidents (please note these numbers include med errors, PUs, falls also shown separately above)	Number of incidents by harms;	
	No Harm	
	Low Harm	
	Moderate Harm	
	Severe Harm	
	Death	
Referrals	No. of new referrals	
	% non-malignant referrals per quarter	
Statistics - IPU	IPU occupancy (excluding respite)	1,482 bed nights p.a.
	% IPU occupancy (excluding respite)	
	Number of IPU referrals unfulfilled	
Length of Stay (IPU) (excl hospice respite)	Total days stayed	
	Total number of patients	
	Average length of stay	
	Number of patients staying more than 30 days	
	No.of days for patients staying more than 30 days	
Pts on an EOL pathway who have an appropriate personalised care plan	Number of deaths recorded (IPU)	
	Number of IEOLCP recorded	
	% of deaths on IPU with IEOLCP recorded	
ACP undertaken whilst with the Service	No. of pts with an ACP undertaken whilst with the service	
	% of total with ACP undertaken whilst with the service	
Statistics - Community	Community FTF contacts	1,934 p.a.
	Community Tel contacts	3,156 p.a.
	Community Total contacts	5,090 p.a.
GSF meetings	No. of GSF meetings attended by WHT staff	
	% of GSF meetings attended by WHT staff	
Statistics - Wellbeing	Daycare (social respite) actual attendances	1,527 p.a.
	Wellbeing actual attendances	509 p.a.
Friends and Family Test	Implementation of staff friends and family test	
	Early implementation of FFT in all outpatient and day case departments 1 January 2015	
	FFT response rates; inpatients	Q3-24%;Q4-30%

	FFT - "Extremely likely to recommend service to Friends & Family"	*80% + = green* *70 -79% = amber* *69% & below= red*
	FFT decreasing negative responses	<1.5%
End of Life	% of people supported to die in their preferred place (PPC)	75%
Complaints	Number of complaints received	N/A
	Percentage of complaints acknowledged within 3 operational days	95% & + = Green 90 -94% = Amber Under 90% = Red
	Percentage of complaints responded to within agreed timescales (20 working days)	
	Number of complaints referred to the Ombudsman	
	Date when last complaints summary published on website	N/A
Staffing	Staffing Levels Publicly displayed	Yes/No
	Clinical Staff turnover	
	Clinical Staff appraisal rate	95% & + = Green 80 -94% = Amber Under 80% = Red
	Clinical Staff Mandatory training rate	
	Clinical Staff Sickness rate	
	Percentage of eligible staff Annual Flu Vaccination	
	Workforce Assurance Framework	
Safeguarding	Percentage of eligible staff trained in L1 Safeguarding Children	95% & + = Green 90 -94% = Amber Under 90% = Red
	Percentage of eligible staff trained in L2 Safeguarding Children	
	Percentage eligible staff trained in L3 Safeguarding Children	
	Percentage staff trained in Safeguarding Adults	
	Percentage staff trained in relation to Mental Capacity Act and DOLs	
Duty of Candour	Number of times duty of candour used	N/A
Mixed Sex accommodation Breach	Number of non-clinically indicated mixed sex accommodation breaches	0 = Green 1 + = Red
Confidentiality / information security	Number of Incidents and breaches	0
Serious Incidents	Number of serious incidents relating to Pressure Ulcers	
	Number of serious incidents relating to Falls	
	Number of serious incidents - other	N/A
Never Events	Number of Never Events	0
Service Provision	Service Availability / Service Updates	
	Support provided to non-cancer networks	
	Specialist sessions for non-cancer diagnosis	
	Outcomes	
Safety	CAS Alerts	
	NICE Technology Appraisals & Clinical Guidance	
	RCA	

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	14 November 2016
Officer	Sally O'Donnell, Dorset Healthcare University Foundation Trust
Subject of Report	**Dorset Healthcare University Foundation Trust CQC March 2016 inspection**
Executive Summary	The purpose of this report is to update the Dorset Health Scrutiny Committee on progress with the Quality Improvement Plans for Dorset Healthcare addressing the findings for the 16 core services from the CQC Comprehensive inspection as well as the re-inspection of 7 core services in March 2016.
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by Dorset Healthcare University Foundation Trust.
	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW

	Other Implications:
Recommendation	The committee is asked to note: • The progress made toward full implementation of the action plans and no red actions currently. • The updated position following the re-inspection in March 2016.
Reason for Recommendation	The Dorset Health Scrutiny Committee requested an update on the March 2016 re-inspection.
Appendices	Appendix 1 shows the comparison between the ratings for each domain from the comprehensive inspection and the current ratings following the re-inspection.
Background Papers	8th March 2016 – CQC Action Plan Update
Officer Contact	Name: Sally O'Donnell Tel: 01202 277127 Email: sally.o'donnell@dhuft.nhs.uk

1. INTRODUCTION

1.1 The purpose of this report is to update the Dorset Health Scrutiny Committee on progress with the actions arising from the CQC comprehensive inspection undertaken in June 2015 and the re-inspection visit of seven core services in March 2016.

1.2 New action plans against the seven core services re-inspected in March 2016 were submitted to the CQC on 10 October 2016. Reporting against these plans will commence next month.

2. SUMMARY OF PROGRESS (June 2015 inspection)

2.1 The rating system used is:

Complete	Action completed – Action has been reported as green for three consecutive PMO updates.
Green	Action on target or met
Amber / Green	Work in progress, expected to meet deadline
Amber	Action in progress but at risk of not achieving the deadline
Red	Action not progressing and will not/has not met the deadline

2.2 Of the 60 'must do' recommendations:

- 50 (82%) are rated green or complete
- 3 (5%) are rated amber/green and are in progress and on target to meet the target date
- 8 (13%) are rated amber and are at risk of not achieving the target
- No actions are rated red.

2.3 Of the 88 'should do' recommendations:

- 66 (75%) are rated green or complete
- 9 (10%) are rated amber/green (coded blue) and are in progress and on track to meet the target date
- 13 (15%) are rated amber and are at risk of not achieving the target date
- No actions are rated red

2.4 The Trust's quality assurance team continues to undertake regular assurance visits to all teams. Each action plan has a senior manager leading the improvements and an Executive Director overseeing the progress. The Trust Board review progress on a monthly basis.

3. RE-INSPECTION March 2016

3.1 In March 2016 the CQC undertook a re-inspection of seven core services in order to review progress against the actions identified at the comprehensive inspection undertaken in June 2015.

3.2 The seven core services re-inspected were:

- Wards for older people with mental health problems
- Community based mental health services for adults
- Community based services for older people with mental health problems
- Long stay rehabilitation wards
- Crisis and health based places of safety
- Specialist community mental health services for children and young people (CAMHS Community)
- Urgent Care Services (Minor Injury Units)

3.3 The final reports were published on the CQC website on Wednesday 7 September 2016. The CQC presented their findings at a Quality Summit on Monday 3 October 2016

3.4 The Trust received no enforcement notices from the CQC during this inspection.

4. CQC FINDINGS – RE-INSPECTION VISIT

4.1 Four of the core services re-inspected have moved from a rating of 'requires improvement' to a rating of 'good'. These are:

- Wards for older people with mental health problems
- Long stay rehabilitation wards
- Specialist community mental health services for children and young people (CAMHS Community)
- Urgent Care Services

4.2 Three core services that were re-inspected are still rated as 'requires improvement':

- Community based mental health services for adults
- Community based services for older people with mental health problems
- Crisis and health based places of safety

4.3 Appendix 1 shows the comparison between the ratings for each domain from the comprehensive inspection and the current ratings following the re-inspection.

4.4 The reports indicate that progress has been made across all of the services re-inspected. However, the three services where the rating did not change did not demonstrate that improvements had been made across all areas at the pace expected. The report states:

"The Trust had made considerable progress since our last inspection however the lack of progress in community mental health services meant that although four services had their ratings changed to Good, the overall trust rating of Requires Improvement remains the same."

4.5 The table below highlights the changes to the rating since the comprehensive inspection in June 2016.

	October 2015	September 2016
Core Service Areas	**16**	**16**
Outstanding	2	2
Good	4	8
Requires Improvement	10	6
Inadequate	0	0
5 Domains in 16 services (80 total)		
Outstanding	4	4
Good	43	54
Requires Improvement	30	21
Inadequate (MIU and CAMHS Community safety domain)	2	0
Not rated	1	1

4.6 Areas of good practice highlighted in the reports

- **Urgent care services,** which consist of the minor injuries units, had improved greatly. Staff felt engaged with the improvements and felt that leadership had improved.

- **Child and adolescent mental health services** now considered risk at every point in the child's pathway through services. Waiting lists were monitored and staff were enthusiastic about the changes and fully engaged in the improvements to the service.

- The Trust had addressed concerns around **privacy and dignity in older people's mental health wards.** This included addressing culture on the wards as well as environmental challenges. Staff were warm, kind and respectful when interacting with patients.

- CQC found a full and comprehensive programme of therapeutic, recovery focussed activities across the **long stay rehabilitation wards** of Nightingale court, Nightingale House and Glendinning ward.

- **Glendinning ward** had created a new arts and crafts room and had audited the success of its patient led activities program. Activity plans were patient led and designed around personal needs and choices.

4.7 Areas of concerns

- The Community Mental Health Teams and Crisis Team still had challenges with staffing and relationships between the teams still need to be improved.

- Record keeping still had gaps. There was an action plan by the Trust in place to address this and the Trust has kept CQC informed of further progress since their visit.

- There had been progress in some areas including the introduction of a new crisis line and a staffing review which identified shortfalls in team sizes which was being addressed.

- Community Mental Health Teams for older people also had inconsistent record keeping. CQC were concerned that application of the Mental Capacity Act was not embedded in practice. Teams still worked in isolation and practice and e-learning was not shared. However, a strategic review of older people's mental health services was being undertaken and caseload sizes had been reduced.

4.8 Three core services rated 'requires improvement' in the March 2015 comprehensive inspection, have not yet been re-inspected. In the meantime, the organisation continues to focus on delivering the actions required. These services are:

- Community health services for children, young people and families
- Community health inpatient services
- End of life care

5. RECOMMENDATION

5.1 The Dorset Health Scrutiny Committee is asked to note:

- The progress made toward full implementation of the action plans following the 2015 inspection, and no red actions currently.
- The updated position following the re-inspection in March 2016.

Appendix 1 – 2015 Mental Health ratings

Dorset HealthCare University NHS Foundation Trust

Name of provider	Dorset Healthcare University NHS Foundation Trust					
	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units (PICU's)	Good	Good	Outstanding	Outstanding	Good	Outstanding
Long stay/rehabilitation mental health wards for working age adults	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Forensic inpatient / secure wards	Requires Improvement	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Wards for people with a learning disability or autism	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Community-based mental health services for adults of working age	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Mental health crisis services and health based places of safety	Inspected but not rated	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Specialist community mental health services for children and young people	Inadequate	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Community-based mental health services for older people	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community mental health services for people with a learning disability or autism	Good	Good	Good	Good	Good	Good
Forensic Community	Good	Outstanding	Outstanding	Good	Good	Outstanding
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Appendix 1 – 2016 Mental Health ratings

Dorset HealthCare University NHS Foundation Trust

Name of provider	Dorset Healthcare University NHS Foundation Trust					
	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units (PICU's)	Good	Good	Outstanding	Outstanding	Good	Outstanding
Long stay/rehabilitation mental health wards for working age adults	Requires Improvement	Good	Good	Good	Good	Good
Forensic inpatient / secure wards	Requires Improvement	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Wards for people with a learning disability or autism	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Community-based mental health services for adults of working age	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Mental health crisis services and health based places of safety	Inspected but not rated	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement
Specialist community mental health services for children and young people	Good	Good	Good	Requires Improvement	Good	Good
Community-based mental health services for older people	Good	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Community mental health services for people with a learning disability or autism	Good	Good	Good	Good	Good	Good
Forensic Community	Good	Outstanding	Outstanding	Good	Good	Outstanding
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good	Requires Improvement

Appendix 1 – 2015 Community Health ratings

Dorset HealthCare University NHS Foundation Trust

Name of provider	Dorset Healthcare University NHS Foundation Trust					
	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires Improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Community health inpatient services	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of life care	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community dental services	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
MIU	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Appendix 1 – 2016 Community Health ratings

Dorset HealthCare University NHS Foundation Trust

Name of provider	Dorset Healthcare University NHS Foundation Trust					
	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires Improvement	Good	Good	Good	Good	Good
Community health services for children, young people and families	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Community health inpatient services	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of life care	Good	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Community dental services	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable	Not Applicable
MIU	Good	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	14 November 2016
Officer	Interim Director for Adult and Community Services
Subject of Report	**Joint Health Scrutiny Committee re Clinical Services Review – Update**
Executive Summary	This report provides a brief update re the Joint Committee which has been convened to scrutinise the NHS Dorset Clinical Commissioning Group's Clinical Services Review. The most recent formal Joint Committee took place on 27 October 2016. The minutes of this meeting can be found at Appendix 1. The purpose of this meeting was for the CCG to share the outcome of the Mental Health Acute Pathway Review and the proposals, which were approved by the CCG Governing Body on 19 October and will now go forward for NHS England assurance and public consultation. The Committee heard about the reasons for the review, the work which has supported it (including needs analysis, extensive view seeking and modelling), the resultant shortlisting of options and the criteria on which the recommended option was based. The Review had a 'co-production' focus, with the intention that all stakeholders would feel engaged and able to contribute to the proposals. In addition information was presented regarding the progress of a Review of Dementia Services, which was originally identified as a priority by the CCG in their 2014-19 5-Year Plan, but was postponed due to the commencement of the Clinical Services Review. The current Dementia Services Review now has a wider scope, taking a 'whole system' approach and including some local authority dementia services.

	The Chairman of the Joint Health Scrutiny Committee made the following observations and comments regarding the meeting on 27 October: *Chairman's comments on the presentation of the Mental Health Acute Care Pathway Review.* *1. A lengthy, well considered and comprehensive presentation was made by Kath Florey-Saunders on behalf of the CCG following the acceptance of the report by the Board of the CCG. It was clear from the beginning that the many complaints, concerns and worries expressed in the past had been heard and that action was to be taken to resolve such matters where possible.* *2. Of particular note was the concern over transport in rural areas and the idea that patients should be not more than 25 minutes of travel by car from a place of support/refuge (Community Front Rooms) or 33 miles from more intensive inpatient support. During questions it was stated that the Trust would look towards solving the problems of patients who had no car transport available to them by the use of a taxi.* *3. It was also noted that in settings where patients were to be treated in a ward, then a minimum of ratio of staff to beds would be required. This could lead to the closure of several wards in the more rural parts of Dorset. The proposed closure of the Linden Ward in Weymouth was of particular concern together with the relocation of beds to Forston - an area to which there is little access by public transport.* *4. Considerable doubt was expressed by the Dorset members regarding the 30/70 split model proposed for demand for treatment as they felt that the West, with its special difficulties, was not being treated fairly.* *5. Attendance at the Committee was poor.* *6. The Committee welcomed the report and looked forward to seeing the outcome at a later date. However, it has to be pointed out that it would be helpful if future reports could be available to be sent out through DCC at the same time as other material, to arrive with members seven days before the day of a meeting. I acknowledge that there were special circumstances in this instance.* *Ronald Coatsworth* Further meetings of the Joint Health Scrutiny Committee will need to be convened towards the end of the CCG's formal 12 week public consultation period, to formulate a response from the Committee, and again after the consultation has ended, to review

	the process. In order that stakeholders' views can considered prior to the formulation of a response to the consultation, it is suggested that an Inquiry Day be arranged (date dependent on the CCG timescales).
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Minutes of Joint Health Scrutiny Committee meeting on 27 October 2016.
	Budget: Not applicable.
	Risk Assessment: Current Risk: LOW Residual Risk LOW
	Other Implications: None.
Recommendation	1 That members note and comment on the report. 2 That members agree to the setting up of an Inquiry Day to coincide with the public consultation to be launched by the CCG.
Reason for Recommendation	The Committee supports the County Council's aim to help Dorset's citizens to remain safe, healthy and independent.
Appendices	1 Minutes of Joint Health Scrutiny Committee 27/10/2016
Background Papers	Committee papers – Joint Health Scrutiny Committee: http://dorset.moderngov.co.uk/ieListMeetings.aspx?CommitteeId=268 NHS Dorset CCG Governing Body reports, 19/10/2016: http://www.dorsetccg.nhs.uk/aboutus/19-october-2016.htm
Officer Contact	Name: Ann Harris, Health Partnerships Officer, DCC Tel: 01305 224388 Email: a.p.harris@dorsetcc.gov.uk

Helen Coombes
Interim Director for Adult and Community Services
November 2016

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Joint Health Scrutiny Committee - Clinical Services Review

Minutes of the meeting held at on Thursday, 27 October 2016

Present:

Ronald Coatsworth (Chairman)
Ros Kayes, Bill Batty-Smith, Vishal Gupta, David d'Orton-Gibson, Rae Stollard and Roger Huxstep.

Officer Attending:
Jason Read (Democratic Services Officer) and Ann Harris (Health Partnerships Officer), Kath Florey-Saunders, (NHS Dorset Clinical Commissioning Group), Eugine Yafele (Dorset Healthcare University NHS Foundation Trust), Elaine Hurll (NHS Dorset Clinical Commissioning Group), Dr Paul French (NHS Dorset Clinical Commissioning Group) and Diane Bardsley (NHS Dorset Clinical Commissioning Group).

Others in Attendance:
Mr Simon Williams (Public Speaker).

(Notes: These minutes have been prepared by officers as a record of the meeting and of any decisions reached. They are to be considered and confirmed at the next meeting of the Joint Health Scrutiny Committee – Clinical Services Review).

Apologies for Absence

9 Apologies for absence were received from Jennie Hodges (Borough of Poole), Phillip Broadhead (Bournemouth Borough Council), Chris Carter (Hampshire County Council), David Harrison (Hampshire County Council), John Parham (Somerset County Council), Hazel Prior-Sankey (Somerset County Council) and Linda Vijeh (Somerset County Council).

Code of Conduct

10 There were no declarations by members of disclosable pecuniary interests under the Code of Conduct.

Cllr Ros Kayes added that she was employed in the mental health profession outside of Dorset. As this was not a disclosable pecuniary interest she remained in the meeting.

Minutes

11 The minutes of the meeting held on 2 June 2016 were confirmed and signed.

Public Participation

12 Public Speaking

There were no public questions received at the meeting in accordance with Standing Order 21(1).

Mr Simon Williams, Chairman of the Hughes Unit Group Supporters, addressed the Committee in relation to the Mental Health Acute Care Pathway Review. Mr Williams supported the majority of the proposals in the report, but expressed his concerns with access issues, patient safety and bed numbers, which he felt had all been inadequately addressed in the report.

Petitions

There were no petitions received at the meeting in accordance with the County Council's Petition Scheme.

Mental Health Acute Care Pathway Review

13 The Committee received a presentation led by the NHS Clinical Commissioning Group (CCG) which updated the Committee on the Mental Health Acute Pathway Review. The presentation reminded the Committee of the purpose and aims of the review and gave an overview of the work that had been undertaken to achieve these aims as well as some detail around the preferred way forward.

Some Councillors raised concerns around how the proposals could be achieved without increasing the budget or staffing levels. It was clarified that budget and staff implications had been considered when forming the proposals, but much of the work would rely on continuing the strong relationships with voluntary sector services.

Concerns were raised over travel distances and duration and how patients in the rural areas of Dorset would access services if they did not have access to a vehicle. The CCG confirmed that funding had been put aside to investigate this area of concern and they would be testing access for all parts of the county. Although not the preferred option, it was acknowledged that patients in some areas may need to be made entitled to a taxi service if they did not fall within the distance and duration guidelines set out in the report.

Further concerns were raised in relation to the potential closure of the Linden Unit in Weymouth. It was suggested that Weymouth and Portland currently had a higher level of need than anywhere else in Dorset and therefore closing the Linden Unit would be detrimental to patients. It was noted that the Linden Unit was an isolated facility with associated staffing difficulties, not currently fit for purpose and would require significant funding to bring it up to the expected and required standards. The community front rooms and proposals around retreats would help to address much of the demand in the Weymouth and Portland area and in rural Dorset.

The final business case would be prepared for the CCG's governing body for July 2017. The Committee felt confident that the CCG would take their comments under consideration when preparing the final business case.

Noted.

Dementia Services Review

14 The Committee received a presentation from the NHS Clinical Commissioning Group (CCG) on the Dementia Services Review. The presentation outlined what Dementia was and how it impacted the community.

Updated national targets for Dementia services had recently been released. The new targets along with the need to review current services would help shape the review and identify potential areas for change.

Councillors asked what the expected outcome of the review would be and what changes would likely be implemented as a result. The CCG explained that it was difficult to predict at such an early stage and it would depend heavily on the feedback received from the community. However, improved and more efficient services were the overall aim of the review.

The review was scheduled to run until 2018. It was asked that with the current pressures and challenges the CCG were faced with, could services be sustained in the current way for that amount of time. It was noted that many of the challenges were

currently caused by workforce issues. Some inpatient units were currently closed on a temporary basis due to staff shortages. It was hoped that the review would help to mitigate some of the challenges, but as with any review of this kind, it would take time to ensure it was completed correctly. The need for health and social care services to work together was emphasised.

The CCG would come back to the Committee at a later date to provide an update on how the review was going.

Noted.

Meeting Duration: 10.00 am - 12.35 pm

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Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	14 November 2016
Officer	Paul Rennie, NHS Dorset Clinical Commissioning Group
Subject of Report	**Continuing Healthcare**
Executive Summary	'NHS continuing healthcare' (CHC) means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS continuing healthcare places no limits on the settings in which the package of support can be offered or on the type of service delivery. This report summarises the trends in activity with regard to CHC and sets out the work of the recently established CHC Steering Group.
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Report provided by NHS Dorset Clinical Commissioning Group.
	Budget: The total budget for Continuing Healthcare for the Clinical Commissioning Group for 2016/17 is £62,045,442.

	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk LOW
	Other Implications:
Recommendation	It is recommended that the Dorset Health Scrutiny Committee note and comment on the report.
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to help Dorset's citizens to remain safe, healthy and independent.
Appendices	1 NHS Dorset CCG: Continuing Healthcare Health Scrutiny Report, November 2016 2 Eligibility criteria – Flow chart 3 CHC Steering/Implementation Group Action Plan, August 2016 4 NHS Continuing Healthcare Benchmarking Analysis – CCGs 5 Q1 2013/14 – Historic data for comparison – taken from report to Dorset Health Scrutiny Committee, 19 November 2013
Background Papers	Report to Dorset Health Scrutiny Committee, 19 November 2013 (agenda item 8): Dorset Health Scrutiny Committee - Agenda papers 19 November 2016
Officer Contact	Name: Paul Rennie Tel: 01305 368900 Email: Paul.Rennie@Dorsetccg.nhs.uk

Appendix 1

NHS Dorset Clinical Commissioning Group

Continuing Healthcare

Health Scrutiny Report November 2016



Supporting people in Dorset to lead healthier lives

1. Introduction

1.1 'NHS continuing healthcare' means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been found to have a 'primary health need'. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. The actual services provided as part of the package should be seen in the wider context of best practice and service development for each client group. Eligibility for NHS continuing healthcare places no limits on the settings in which the package of support can be offered or on the type of service delivery.

1.2 Individuals who need ongoing care/support may require services arranged by Clinical Commissioning Groups (CCGs) and/or Local Authorities (Las). CCGs and LAs therefore have a responsibility to ensure that the assessment of eligibility for care/support and its provision takes place in a timely and consistent manner. If a person does not qualify for NHS continuing healthcare, the NHS may still have a responsibility to contribute to that person's health needs – either by directly commissioning services or by part-funding the package of support.

1.3 Assessments of eligibility for NHS continuing healthcare should be organised so that the individual being assessed and their representative understand the process, and receive advice and information that will maximise their ability to participate in informed decision-making about their future care. Decisions and rationales that relate to eligibility should be transparent from the outset for individuals, carers, family and staff alike.

1.4 The National Framework (revised November 2012) sets out the principles and process for NHS continuing healthcare and NHS-funded nursing care. It reflects the new structures created by the Health and Social Care Act 2012 effective from 1 April 2013.The previous Primary Care Trusts' (PCTs') responsibilities and legal duties in relation to NHS continuing healthcare have, as of the 1 April 2013, transferred to CCGs and, in the case of serving members of the armed forces and their families, or prisoners, to the NHS Commissioning Board.

1.5 In addition the National Framework and supporting documents set out more detailed best practice on decision-making and related issues such as case management, reviews, commissioning and personalization. There are three national tools which all CCGs are required to use in making decisions on eligibility for NHS continuing healthcare.

1.6 These are:

- the Checklist (an initial screening tool);
- the Decision Support Tool (used to consider a person's needs across a set of "domains" to assist in reaching a recommendation on eligibility);
- the Fast Track Pathway Tool, used in situations where an individual requires immediate access to appropriately funded care because they have a rapidly deteriorating condition and may be entering a terminal phase. This tool, when used, replaces the need to use the Checklist and Decision Support Tool.

1.7 The process for consideration for Continuing Health care eligibility is identified in Appendix 2.

1.8 Patients found eligible for NHS continuing healthcare receive funding for health and personal care needs in full regardless of their financial situation either by means of a commissioned package of care or a Personal Health Budget (PHB). However, this does not exclude recipients from full access to mainstream healthcare services and certain elements of social care provision.

1.9 Due to the different funding regimes, in that NHS care is free at the point of delivery and social care is means tested, there are tensions in the system. NHS continuing healthcare can be a litigious area and frequently subject to challenge and appeals against decisions reached. This means that the application of the National Framework in a robust manner by both CCGs and LAs is vital not only to ensure consistency but also to demonstrate equitable application of the Framework across England, which is monitored by NHS England on a quarterly basis.

1.10 Children and Young People's Continuing Care relates to NHS funded care when a child or young person has complex needs arising from disability, accident or illness that cannot be met by existing universal or specialist services alone. The process is in three phases; referral via a Checklist; a Decision Support Tool (with 10 domains) with recommendation and an Independent Panel to determine eligibility. This differs to adults CHC which has12 domains and an assessment to determine a primary health need. Decision is made by the CCG and not referred to an independent panel. The domains consider the development of the child and when assessing will consider for each care domain is over and above what would be expected for a child or young person of that age. The assessment is evidence based and consideration is given to the preferences of the child or young person's family; a holistic assessment of the needs, reports and risk assessments from the Multi-Disciplinary Team which includes representatives from Education and Social Workers as well as specialists such as Paediatricians and Community Children's nurses. In addition the health needs of other family members and the proposed environment of care is also considered. There is no assessment of a Primary Health need as in the case of Adults CHC.

1.11 A child is likely to have continuing care needs if assessed as having a severe or priority level of need in at least one domain of care, or a high level of need in three domains of care. The whole process should take no longer than 6 weeks. If found eligible a review is carried out at 3 months and then again annually in much the same way as Adults CHC.

1.12 There is also the ability to Fast Track a child who is rapidly deteriorating and may be entering a terminal phase. Commissioning of care will also consider the level of care provided by the family to ensure respite is provided where the family wish to largely provide care for the child or young person. This requires a social care assessment and agreement between the CCG and the Local Authority of the respective contribution towards that respite care.

2 Adults Continuing Healthcare

2.1 Table 1 below shows the financial position for both Adult and Children's continuing healthcare at end of month 5 2016-17 (the total annual budget for CHC is £62,045,442 – not including Funded Nursing Care, for which the budget is £7,960,277).

TABLE 1

	CHC	FNC	Children's CHC
Expenditure to date	£23 881 586	£5 958 142	£ 324 802
Forecast Outturn	£54 669 495	£12 736 857	£ 2 895 577
		£ 4.7 million overspend position due to 40% uplift	

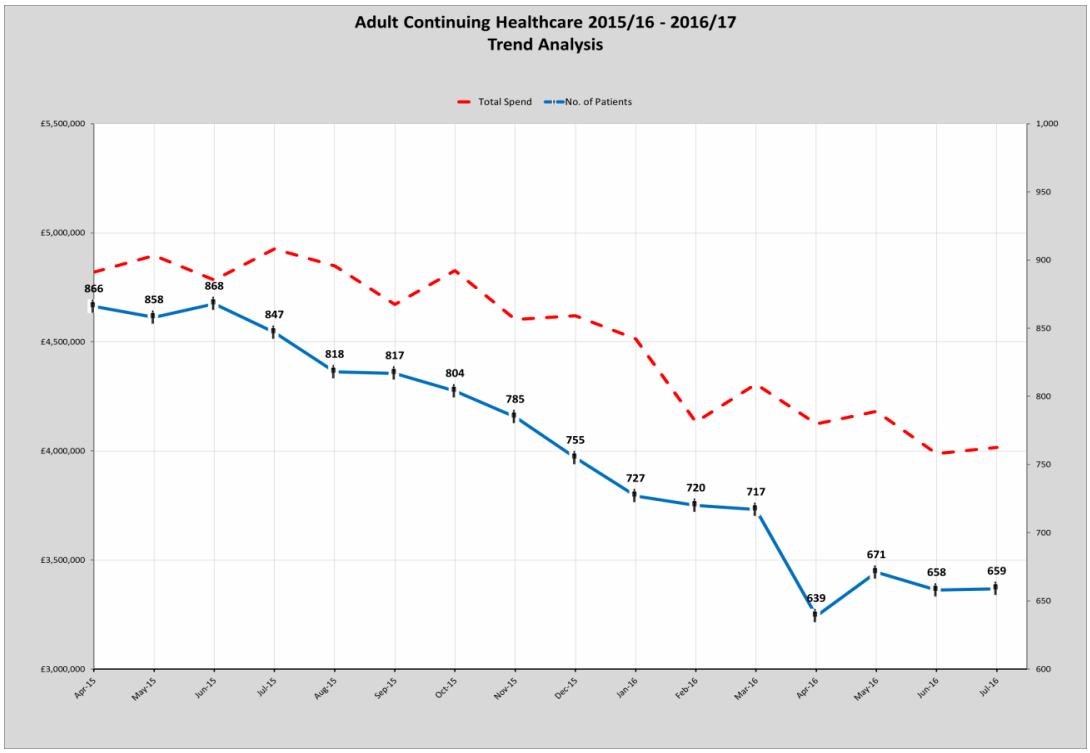
2.2 Table 2 tracks the activity and trend analysis for the previous 15 months. This table has been included to illustrate the work that has been undertaken by the continuing healthcare teams around both decision making and reviews.

2.3 The latest figures are broadly in line with NHS England benchmarking figures that show approxiamately1% of the population are in receipt of NHS funded Continuing Healthcare at any one time.

2.4 The impact of this work is also reflected in the latest benchmarking data released by NHS England, where Dorset CCG is ranked 109 for standard CHC activity, 108 for fast track activity with an overall ranking of 120. These rankings are out of a total of 209 clinical commissioning groups.

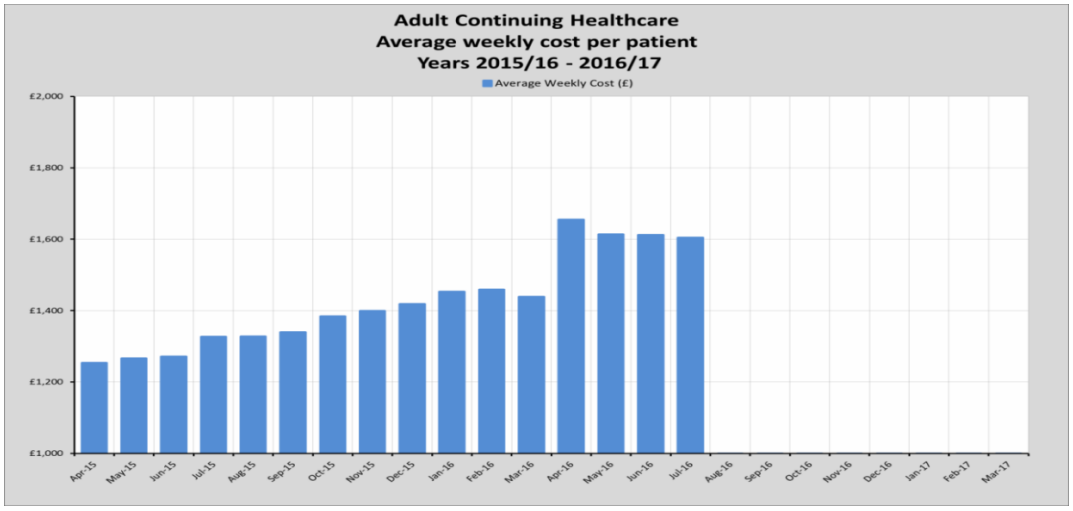
2.5 The data relating to total spend is tracking the number of patients as expected. By undertaking the scheduled reviews of those patients in receipt of funding in a timely manner, the team has been able to identify those patients who are no longer eligible.

TABLE 2



2.6 Table 3 below relates to the average weekly cost per patient. The table illustrates the point that those patients who continue to be funded by continuing healthcare are those with more complex clinical needs, and who require higher levels of input to meet those needs.

TABLE 3



2.7 The Previous Un-assessed Periods of Care (PUPO) project is coming to a close, and all but five cases had their initial review by September 30, in line with NHS England target. All of these cases assessed will now have to have a decision on eligibility before the end of December 2016. NHS England have yet to make the announcement of the next closedown with associated timescales. The proposed closedown was due before ministers; however the rolling programme of closures for PUPOCS was not included, leading to a further 6 week consultation prior to any announcement. Dorset CCG is currently ranked 71 of the 209 CCG's on this measure, showing that Dorset CCG is in the top half of performance against this indicator, relating to decisions made.

2.8 Work has commenced with the 3 local authorities relating to the introduction of the NHS Standard contract for 2017-18, and the impact this will have on patient placements. Joint working with Dorset County Council on market engagement and management will begin October 2016. Internal processes within the CHC team will need to be adapted in order to ensure maximum benefit is achieved when the contract comes into place, and a series of meetings are taking place to ensure the CCG remains fit for purpose to deliver these benefits.

2.9 Dorset CCG is currently one of two CCG's in the South West currently using the Continuing Healthcare Assurance Tool (CHAT) in order to record NHS England Key Lines of Enquiries (KLOE) relating to continuing healthcare, and the Head of Service was asked to feedback at the NHS England event on September 9 on the Dorset experience to date. The tool can be accessed by NHS England in order for them review performance and ensure that continuing healthcare assurances are met.

2.10 Current performance indicates that Dorset CCG is meeting all KLOE's either fully or partially, and an action plan is in place in order to address those areas requiring further work

3. Personal Health Budgets

3.1 The personal health budget agreement has been revised by Beachcroft solicitors in order to incorporate changes to reflect redundancy payments that may be required when there is no longer a need for the personal assistants that are employed. This new agreement will replace those currently in use when the budget holder is next reviewed.

3.2 There are currently 96 adult budget holders with a year to date expenditure of £3.4 million, an underspend position of £445 thousand against the annual budget. This can be explained by patients found no longer eligible, passing away or amendments to the originally set budget due to changes in clinical need. At present there remains 1 unsigned agreement; however a date is to be arranged to rectify this position, dependent on the budget holder's availability.

3.3 A proposal to introduce personal health budgets for fast track cases to ensure patients identified at the end of their lives are discharged in a timely manner has been agreed. This will be piloted and reviewed after 10 cases have been approved, and will commence in October 2016. Interest in this initiative has been shown by a number of other CCG's and the Head of Service attended a regional event on 9 September hosted by NHS England to discuss this.

4. Children's Continuing Healthcare

4.1 Currently there are 59 children in receipt of continuing healthcare funding. Of this number, 33 are in receipt of a personal health budget.

4.2 The budget position for children's CHC is reporting an underspend of £1.47 million with a forecast outturn position of a £895 000 underspend.

4.3 There have been some challenges within the staffing of the children's team, however these have now been resolved and the end to end function is being mapped in order to ensure it remains fit for purpose.

5. Funded Nursing Care (FNC)

5.1 The FNC rate has been increased nationally by 40%, backdated to April 2016 which is an additional £250 000 a month spend on FNC, equating to a £3 million for the year cost pressure. Over 1300+ FNC patients will have FNC at £156.25 per week backdated to April 2016.

6. CHC STEERING GROUP

6.1 The first CHC joint steering and implementation group took place in April 2016 and has met now on three occasions. The work of the group is centred on an action plan. The most recent version of this plan is attached with this report (appendix 3) and outlines the current areas of work.

6.2 The main areas of challenge for the steering group are:

- To develop a process for capturing levels of funded activity across health and social care. This information is important for a number of workstreams as it is expected that this will identify the level of opportunity for efficiency across the various policies/processes that are under development within the plan. The information is currently available from CHC and this is provided at each steering group;

- To develop hospital in reach service to ensure quality of applications improves and therefore reduces time from initial checklist to discharge, at the same time refining the funding in / funding out arrangements and to promote eligibility applications being made outside of hospital;

- As indicated within the plan some of the workstreams within the action plan are interdependent upon the Cost of Care work programme which reports to Joint Commissioning Officers Group.

6.3 The CHC steering group is developing clear programmes of work. The group members are committed to working together and demonstrate a desire to progress the areas identified within the plan.

6.4 Attendance at the steering group is monitored to ensure that there is representation from each of the four organisations.

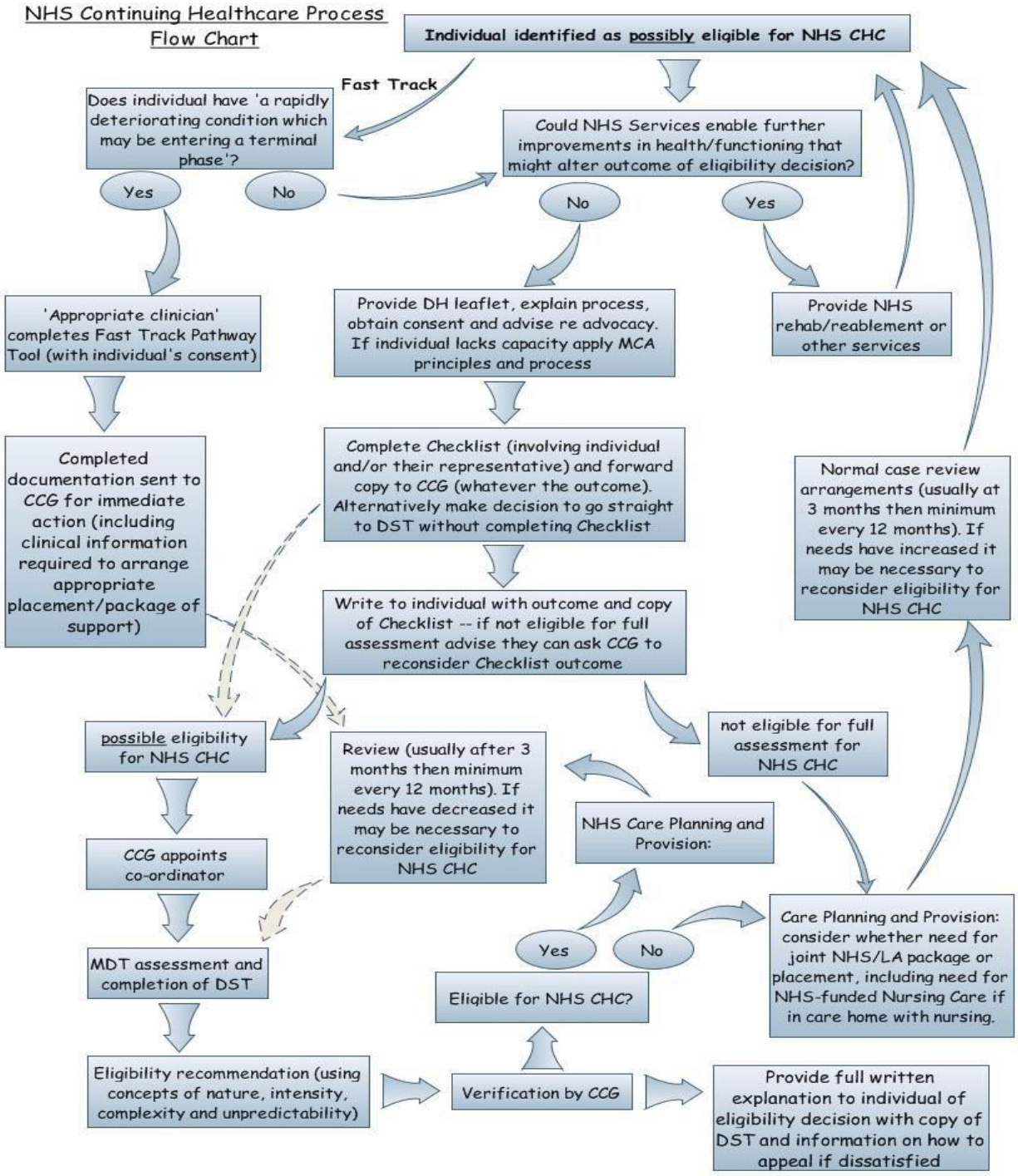
7. Conclusion

7.1 Although the position within NHS funded Continuing Healthcare and Funded Nursing Care remains challenging, the work that is being undertaken is ensuring that these challenges are managed.

The Committee is asked to **note and comment on** this report.

Appendix 2

Eligibility Consideration



APPENDIX 3 - CONTINUING HEALTH CARE STEERING/IMPLEMENTATION GROUP ACTION PLAN
VERSION 4 – 25 August 2016

No.	Area for action	Vision Evidence/Outcome measure	Lead Person Responsible	Timescale for completion	Progress
1.0	Joint Funding				
1.1	Joint Funding Policy	Policy to be finalised and published	Tim Branson	30/09/16	The draft policy requires some refinement particularly in relation to when the policy should apply. Although policy is being finalised some principles of joint funding are already being applied. The details of the policy will be crucial to identify the likely number of people to whom this may apply.
1.2	Policy implementation	The policy to be published and any relevant training made available	Tim Branson	01/09/16 (Policy) 31/12/16 (Training)	To be agreed once policy finalised.
1.3	Policy Monitoring	To be added to monitoring dashboard	Paul Rennie	30 June 2016	Complete
2.0	Joint Assessment and Care Planning				
2.1	Identify cohort of people to pilot joint assessment and care planning	Increase in number of people with joint assessment and plans, to include reference to 1:1, 2:1 policy and personal health budgets	Betty Butlin and David Palmer	August 2016	17/06/2016 this will be piloted at Birds Hill. To commence 1 July 2016. Pilot will run for three months. Steering Group will receive evaluation October 2016. In addition Dorset County Council are going to review a cohort of high intensity packages, linking with CHC and Dorset HealthCare. The review will run over next 2 months.
3.0	Disputes				

No.	Area for action	Vision Evidence/Outcome measure	Lead Person Responsible	Timescale for completion	Progress
3.1	Disputes Policy	Policy to be finalised and published	Betty Butlin	TBC by policy lead	Policy in development
3.2	Policy implementation	The policy to be published and any relevant training made available	Betty Butlin	As above	
3.3	Policy monitoring	To be added to monitoring dashboard	Paul Rennie	31 July 2016	Complete
4.0	Transfers of care				
4.1	Checklist: To progress the principle of different approaches to checklist to ensure consideration is recorded when outcome of eligibility is not clear. If clearly eligible prior to checklist, proceed to DST, if outcome is clearly not eligible checklist not required.	Clear local guidance issued that is National Framework compliant as to the application of the Checklist, i.e. when and in what circumstances a Checklist must be completed and when and in what circumstances consideration of CHC can be evidenced without the need for a Checklist	Paul Rennie	Ongoing programme of training	In reach staff and training for RBH to commence shortly, with emphasis on which patients should be subject to checklist. Currently work also underway at Yeovil hospital to assist (30% DCC hospital discharges are from YDH) All hospitals have been sent framework guidance (Para.68) as to who should be assessed. PR and operational managers, together with staff have attended Acute hospitals to discuss issues with discharge teams. Proactive management of CHC identified patients is on-going, and FOH pathway has been extended to YDH to facilitate discharge as necessary.
4.2.	Decision support tool	% hospital discharge DSTs completed out of hospital	Paul Rennie	On-going programme	Getting it Right training focussing on appropriateness of completing DST in hospital,

No.	Area for action	Vision Evidence/Outcome measure	Lead Person Responsible	Timescale for completion	Progress
4.2 a 4.2 b	To progress completing DST out of hospital, Ensure clarity in information required and consider adapting burden of evidence	% of MDT recommendations overturned through lack of supporting evidence Guidance issued on types of evidence required based on experience of good and bad DSTs		of training and support, from both staff attending acute hospitals and remotely	revised DST capturing this information for reporting purposes Current case studies relating to each acute hospital are being utilised in order to inform training. Incidents are also being logged in order to inform
4.3	Funding in – funding out To finalise the funding in funding out principles with CCG and Local Authorities	MoU or agreement produced regarding funding responsibilities for people discharged from hospital requiring DST/eligibility decision.	Paul Rennie	15 October 2017	The policy for funding out is to be reviewed. Current arrangements are that funding is protected for 5 to 7 days, however may be removed sooner if prognosis indicates longer lengths of stay. Exceptions are that high intensity packages are kept for longer as harder to re-start. All to keep in place for minimum of 48 hours following admission
4.4	CHC Staff support to Acute Hospitals	In addition to training packages for hospital and community staff, CHC staff to explore options for providing in reach services to Acute Hospitals (including Yeovil and Salisbury) and community hospitals	Paul Rennie	Ongoing programme of training and support, from both staff attending acute hospitals and remotely	PR and operational managers, together with staff have attended Acute hospitals to discuss issues with discharge teams. Proactive management of CHC identified patients is ongoing, and FOH pathway has been extended to YDH to facilitate discharge as necessary. Together with this the ongoing programme of Getting It Right training continues, together with a bespoke training programme for RBH focussing on fast track applications.

No.	Area for action	Vision Evidence/Outcome measure	Lead Person Responsible	Timescale for completion	Progress
5.0	One to one and two to one				
5.1	Policy		Betty Butlin and Angie Smith		Complete
5.2	Letter to providers from Dorset County Council		Harry Capron		Complete
6.0	Direct Payments and Personal Health Budgets				
6.1	Refine processes and particularly around transition between agencies		Betty Butlin and Angie Smith	31/10/2016	Draft PID and PID Action Plan signed off at CHC Steering Group 25/08/2016. Agreed to extend to include children's direct payments/personal health budgets but this would be at a later stage in the project.
6.2	PHB for fast-track pilot	PHB Fast track process agreed and implemented.	Angie Smith	30/09/2016	Solicitors have requested an updated procedure which outlines how the process would work as key issues is to ensure that PHB funding can be release quickly enough, currently takes 7 days.
7.0	Brokerage				
7.1	PID being developed by Jacqui Elena subsequent actions to be	Agreement on future brokerage services to support three local authorities and CCG	Angie Smith		PID has been circulated. Agreed to carry out follow up meetings with Poole and Bournemouth to review current SLA and subsequent funding arrangements. Principles agreed that unlikely to go to single brokerage but would try as far as possible to pick

No.	Area for action	Vision Evidence/Outcome measure	Lead Person Responsible	Timescale for completion	Progress
	developed once received				up standardisation in approach across Dorset and this may include exploring electronic system to manage brokerage. One key issues that has an interdependency with this work stream is the Cost of care review which reports directly to JCOG
8.0 Children's CHC					
8.1	Transition, SEND and link to joint funding and care planning	Panel Terms of Reference and attendees to be reviewed and revised as necessary Burden of evidence to be reviewed and definitive set of children's framework compliant paperwork to be agreed	Paul Rennie	1 August 2016 1 August 2016	Revised Terms of Reference, including the information data set to be provided to panel for a decision, to be circulated to panel members by 31 August for agreement at September 14 panel
9.0 Training					
9.1	Training plan to be developed to include subject specific training and regular updates for staff in CCG, LA and provider organisations	Training plan developed and will be monitored through the CHC steering group meeting.	David Palmer	30/09/16	DNP meeting with Maggie Blackmore and Kathy Moore on 9 June 2016 to draft training plan 09/06/2016 Update – Agreed Training Plan for 2015/16:

No.	Area for action	Vision Evidence/Outcome measure	Lead Person Responsible	Timescale for completion	Progress
10.0	Cost of Care Review				
10.1	Reporting to JCOG	Updates to be provided to CHC steering group on regular basis	Paul Rennie	TBC.	There has been only one cost of care meeting reviewing the care home arrangements, the findings of this were presented at the CHC summit. There are no further meetings planned. Cost of care at home meetings have been terminated with immediate effect by Poole LA. In light of these facts, it would appear that the brokerage project currently being undertaken will need to progress without input from this forum.
11.00	Management and Finance Reports				
11.1	CHC Management and Finance reports to be provided to each meeting.	Provided at each meeting	Paul Rennie	Quarterly	The management information report is available for each meeting. Complete.
11.2	LA Performance Data	The 3 Local Authorities are requested to submit their activity information in relation to funded care	Angie Smith Tim Branson, Betty Butlin Sue Evans	30/09/16	Each lead to explore within their own organisation what is available. Angie Smith to lead this work linking with the relevant LA Finance and commissioning leads.
12.0	NHS Contracts				
12.1	Joint discussions to review existing contract	Introduction of NHS standard contract into care homes with nursing f*or* financial year 2017-18 and beyond	Paul Rennie	01/04/17	Initial meeting to discuss held with 3 LAs 14 6 2016, final discussion planned for next Cost of Care review meeting, date to be agreed. As the cost of care meetings appear to have concluded, the

No.	Area for action	Vision Evidence/Outcome measure	Lead Person Responsible	Timescale for completion	Progress
	arrangements				implementation of this contract will take place in 2017-18 financial year. Provider meetings together with DCC to commence September 2016 to discuss with providers.

Membership of Steering Group/Implementation Group:

Name	Job Title	Organisation
Vanessa Read (Chairperson)	Deputy Director of Nursing and Quality	NHS Dorset Clinical Commissioning Group
Paul Rennie	Head of Continuing Healthcare	NHS Dorset Clinical Commissioning Group
Harry Capron	Head of Adult Care	Dorset County Council
David Vitty	Head of Adult Social Care	Borough of Poole
Tim Branson	Service Manager	Bournemouth Borough Council
Betty Butlin	Service Manager	Borough of Poole
Andy Sharp	Service Director, Adult Social Care	Bournemouth Borough Council
Sue Evans	Service Manager	Dorset County Council
Angie Smith	Senior CHC Support Services Manager	NHS Dorset Clinical Commissioning Group
David Palmer	Senior CHC Operations Manager	NHS Dorset Clinical Commissioning Group

Appendix 4

NHS Continuing Healthcare Benchmarking Analysis - CCGs

Q1 2016/17

NHS Continuing Healthcare, fast track CHC - people eligible on the last day of the quarter (snapshot) | **Rank – out of 209**

			People Eligible at Quarter End						per 50,000 Population						
Organisation	Organisation Type		Quarter 1, 2015/16	Quarter 2, 2015/16	Quarter 3, 2015/16	Quarter 4, 2015/16	Quarter 1, 2016/17		Quarter 1, 2015/16	Quarter 2, 2015/16	Quarter 3, 2015/16	Quarter 4, 2015/16	Quarter 1, 2016/17		**Quarter 1 Rank**
Wessex	**Regional Team**		**608**	**531**	**589**	**547**	**593**		**13.38**	**11.67**	**12.86**	**11.92**	**12.90**		
Isle of Wight	CCG		10	17	17	8	15		4.28	7.25	7.24	3.40	6.37		**185**
Fareham & Gosport	CCG		62	63	78	58	59		19.17	19.43	23.98	17.81	18.12		**87**
North East Hampshire & Farnham	CCG		39	33	37	49	47		11.20	9.45	10.54	13.95	13.35		**135**
North Hampshire	CCG		28	30	34	34	35		8.10	8.63	9.75	9.73	9.99		**165**
Portsmouth	CCG		31	27	36	32	28		8.82	7.70	10.12	8.94	7.81		**178**
Southampton	CCG		10	16	14	15	21		2.29	3.67	3.15	3.35	4.70		**194**
South Eastern Hampshire	CCG		58	50	61	56	65		17.12	14.71	17.90	16.42	19.04		**81**
West Hampshire	CCG		150	120	149	155	156		17.02	13.58	16.77	17.44	17.52		**93**
Dorset	CCG		220	175	163	140	167		17.15	13.63	12.63	10.82	12.89		**139**

NHS Continuing Healthcare, standard NHS Continuing Healthcare (non fast track) people eligible on the last day of the quarter (snapshot)														
			People Eligible at Quarter End						per 50,000 Population					
Organisation	Organisation Type		Quarter 1, 2015/16	Quarter 2, 2015/16	Quarter 3, 2015/16	Quarter 4, 2015/16	Quarter 1, 2016/17		Quarter 1, 2015/16	Quarter 2, 2015/16	Quarter 3, 2015/16	Quarter 4, 2015/16	Quarter 1, 2016/17		**Quarter 1 Rank**
Wessex	**Regional Team**		**2,291**	**2,260**	**2,031**	**1,934**	**1,947**		**50.43**	**49.67**	**44.36**	**42.14**	**42.36**		**Rank**
Isle of Wight	CCG		169	178	178	169	185		72.39	75.94	75.77	71.84	78.54		**16**
Fareham & Gosport	CCG		141	132	129	128	132		43.59	40.71	39.65	39.31	40.53		**115**
North East Hampshire & Farnham	CCG		137	138	115	132	127		39.34	39.50	32.76	37.59	36.07		**139**
North Hampshire	CCG		130	127	115	115	118		37.59	36.55	32.97	32.90	33.68		**151**
Portsmouth	CCG		195	222	222	209	210		55.50	63.29	62.41	58.40	58.59		**53**
Southampton	CCG		153	155	144	142	146		35.02	35.53	32.44	31.76	32.66		**154**
South Eastern Hampshire	CCG		150	151	113	111	131		44.28	44.44	33.16	32.56	38.37		**124**
West Hampshire	CCG		465	434	327	320	342		52.76	49.10	36.81	36.01	38.40		**123**
Dorset	CCG		751	723	688	608	556		58.53	56.30	53.32	47.00	42.91		**108**

NHS Continuing Healthcare, total number of people eligible on the last day of the quarter (snapshot) (fast track and non fast track CHC)															
			People Eligible at Quarter End						per 50,000 Population						
Organisation	Organisation Type		Quarter 1, 2015/16	Quarter 2, 2015/16	Quarter 3, 2015/16	Quarter 4, 2015/16	Quarter 1, 2016/17		Quarter 1, 2015/16	Quarter 2, 2015/16	Quarter 3, 2015/16	Quarter 4, 2015/16	Quarter 1, 2016/17		**Quarter 1 Rank**
Wessex	**Regional Team**		**2,899**	**2,791**	**2,620**	**2,481**	**2,540**		**63.82**	**61.34**	**57.22**	**54.06**	**55.26**		**Rank**
Isle of Wight	CCG		179	195	195	177	200		76.67	83.19	83.01	75.24	84.91		**34**
Fareham & Gosport	CCG		203	195	207	186	191		62.76	60.14	63.63	57.13	58.64		**125**
North East Hampshire & Farnham	CCG		176	171	152	181	174		50.54	48.94	43.30	51.55	49.42		**158**
North Hampshire	CCG		158	157	149	149	153		45.68	45.18	42.72	42.63	43.67		**177**
Portsmouth	CCG		226	249	258	241	238		64.32	70.99	72.52	67.34	66.40		**89**
Southampton	CCG		163	171	158	157	167		37.31	39.19	35.60	35.11	37.36		**189**
South Eastern Hampshire	CCG		208	201	174	167	196		61.40	59.15	51.07	48.98	57.41		**126**
West Hampshire	CCG		615	554	476	475	498		69.78	62.68	53.59	53.46	55.92		**132**
Dorset	CCG		971	898	851	748	723		75.68	69.93	65.95	57.83	55.80		**133**

Appendix 5

Q1 2013/14 – Historic data for comparison – taken from report to Dorset Health Scrutiny Committee, 19 November 2013

SHA Benchmarking			Highest		Outlier									
Quarter 1 2013/14			Lowest									4% is correct		

CHC	Weighted Population	CHC YTD Activity	Cases per 10,000 weighted pop	Local Rank	National rank	South Rank	CHC YTD Costs £'000's	Costs £'000's per 10,000 weighted pop	Local Rank	National rank	South Rank	CHC Conversion rate	FT Conversion rate	Referrals exceeding 28 days
Dorset	**849,490**	**1,397**	**16**	**4**	**44**	**9**	**£10,666**	**£126**	**4**	**58**	**15**	**53%**	**98%**	**6**
Isle of Wight	146,666	190	13	8	103	23	£1,854	£126	4	56	13	62%	92%	8
North Somerset	222,189	303	14	6	86	20	£2,006	£90	8	119	33	34%	70%	36
North, East, West Devon	915,360	1,878	21	2	16	5	£16,001	£175	1	15	4	60%	99%	28
Portsmouth	211,612	303	14	6	78	16	£1,869	£88	9	128	39	43%	100%	20
Somerset	571,376	1,262	22	1	10	2	£6,442	£113	7	78	24	46%	100%	60
South Devon & Torbay	302,141	513	17	3	40	7	£3,981	£132	3	48	11	41%	100%	42
Southampton	235,830	214	9	9	167	37	£3,442	£146	2	33	6	33%	100%	3
West Hampshire	528,726	800	15	5	63	13	£6,036	£114	6	75	23	4%	100%	0
Wiltshire	459,011	300	7	10	202	45	£3,614	£79	10	152	44	14%	96%	35
										Regional Average		33%	92%	16

NB – The data in this table is not directly comparable to the more recent data from Q1 2-16/17, however it does illustrate the relative position of Dorset in 2013/14 and the level of activity by the end of Quarter 1.

Dorset Health Scrutiny Committee

Dorset County Council

Date of Meeting	14 November 2016
Officer	Interim Director for Adult and Community Services
Subject of Report	**Briefings for information / note**
Executive Summary	The briefings presented here are primarily for information or note, but should members have questions about the content a contact point will be available. If any briefing raises issues then it may be appropriate for this item to be considered as a separate report at a future meeting of the Committee. For the current meeting the following information briefings have been prepared: • Quality Account update: Dorset County Hospital • Dorset Health Scrutiny Committee Forward Plan • Director of Public Health Annual Report 2016
Impact Assessment:	Equalities Impact Assessment: Not applicable.
	Use of Evidence: Briefing reports, referencing wider documents and future agenda items.

	Budget: Not applicable.
	Risk Assessment: Having considered the risks associated with this decision using the County Council's approved risk management methodology, the level of risk has been identified as: Current Risk: LOW Residual Risk: LOW
	Other Implications: None.
Recommendation	That Members note the content of the briefing report and consider whether they wish to scrutinise the matters highlighted in more detail at a future meeting.
Reason for Recommendation	The work of the Committee contributes to the County Council's aim to help Dorset's citizens to maintain health, safety and independence.
Appendices	1. Quality Account update: Dorset County Hospital 2. Dorset Health Scrutiny Committee Forward Plan 3. Director of Public Health Annual Report 2016
Background Papers	None.
Officer Contact	Name: Ann Harris, Health Partnerships Officer Tel: 01305 224388 Email: a.p.harris@dorsetcc.gov.uk

Helen Coombes
Interim Director for Adult and Community Services
November 2016

Appendix 1

Dorset County Council

Briefing for Dorset Health Scrutiny Committee

14 November 2016

Quality Account update: Dorset County Hospital	Contact Name: Nicky Lucey Contact address: Director of Nursing and Quality, Dorset County Hospital Tel: 01305 254992 Email: Nicky.Lucey@dchft.nhs.uk

Members of the Dorset County Hospital Quality Account Task and Finish Group met with the new Director of Nursing and Quality, Dorset County Hospital, on 1 November 2016 to discuss the Trust's progress against priorities for Quarter 1 of the 2016/17 reporting period. It was a positive and useful meeting and the Trust agreed to forward further information to members in response to queries.

The report presented covered the Q1 period of April, May and June 2016 and it was noted that:

- There have been a total of 10 grade II (two) hospital acquired pressure ulcers in Q1 compared to a planned 10% reduction of 12;
- The second meeting of the Hospital Mortality Committee (HMC) took place within this quarter and formally reviewed all hospital deaths in January and February;
- There has been successful recruitment into the post of the Learning Disabilities Nurse Specialist, and an action plan has been developed;
- Despite being over the 3.5% target of occupied beds for delayed transfers of care, there has been an improvement in the percentage and number of bed days lost in 2 months of the quarter;
- Compliance with the timeliness of complaints has not been maintained within all divisions;
- DCHFT partnered with Healthwatch Wessex to carry out a complainant experience survey of making a complaint in the Trust. The full report is publically available: http://www.healthwatchdorset.co.uk/resources/fobbed-experiences-making-nhs-complaint
- Communications skills training for staff supporting those at the end of life have been provided and well evaluated. Training has also been organised for the consultant team.

Briefings for information / note

Appendix 2

Dorset Health Scrutiny Committee – Forward Plan, November 2016

Committee: 14 November 2016			
Format	Organisation	Subject	Comments
Report	Dorset County Hospital	Strategy	To share the Quality Account and the Trust's Strategy for the future
Report	NHS England	Re-designation of the Neonatal Unit at Dorset County Hospital	To share with members the plans to re-designate the Neonatal Unit at DCH to a Special Care Unit
Report	Weldmar Hospicecare Trust	Annual Accounts	To update members re the work of Weldmar and annual accounts
Report	Dorset HealthCare University NHS Foundation Trust	CQC Inspection March 2016, outcome and action plan	To share the outcome of an inspection carried out by the CQC, following on from the inspection carried out in June 2015
Report	NHS Dorset Clinical Commissioning Group	Continuing Health Care	To update members re the latest position and developments
Report	Joint Health Scrutiny Committee	Clinical Services Review, minutes of Joint Committee	To provide an update and the minutes of the meeting held on 27 October 2016
Verbal update	Dorset HealthCare University NHS Foundation Trust	Transfer of patients requiring specialist dementia services from the Chalbury Unit in Weymouth to Alderney Hospital in Poole	To update members following a report to Committee on 7 June 2016 – *This item will be dealt with verbally within the update re the Joint Health Scrutiny Committee (in relation to the Dementia Services Review)*
Items for information or note			
Briefing	Public Health Dorset	Director of Public Health Annual Report 2016	To highlight the focus of the Annual Report
Briefing	Dorset County Hospital	Quality Account Quarter 1	To update members re priorities and progress
Forward Plan	Dorset Health Scrutiny Committee	Forward Plan – Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars

Briefings for information / note

Committee: 9 March 2017			
Format	Organisation	Subject	Comments
Report	The Care Quality Commission	CQC Inspections of GP surgeries in Dorset	To look at the outcomes of local inspections and the quality of GP services
Report	NHS Dorset Clinical Commissioning Group	GP Commissioning Strategy	Following report to Committee on 6 September 2016
Report	Dorset County Hospital	Update re action plan following the CQC inspection carried out in March 2016	Following report to Committee on 6 September 2016
Report	NHS Dorset Clinical Commissioning Group	Non-emergency patient transport services	To provide further information re progress and performance, following report to Committee on 6 September 2016
Report	Joint Health Scrutiny Committee	Clinical Services Review – update	To provide an update regarding progress, as appropriate
Items for information or note			
Forward Plan	Dorset Health Scrutiny Committee	Forward Plan – Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars.

Briefings for information / note

Committee: 16 June 2017			
Format	Organisation	Subject	Comments
Report	Dorset Health Scrutiny Committee	Annual Work Programme	To agree the Programme discussed at annual workshop
Report	Dorset Health Scrutiny Committee	Appointments to Committees and sub-Committees	Following any changes to membership in May 2016
Report	Joint Health Scrutiny Committee	Clinical Services Review – update	To provide an update regarding progress, as appropriate
Items for information or note			
Briefing	Dorset Health Scrutiny Committee	Quality Accounts – commentaries from Dorset Health Scrutiny Committee	Annual report
Forward Plan	Dorset Health Scrutiny Committee	Forward Plan – Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars.

Committee: 4 September 2017			
Format	Organisation	Subject	Comments
Report	Joint Health Scrutiny Committee	Clinical Services Review – update	To provide an update regarding progress, as appropriate
Items for information or note			
Briefing	NHS Dorset Clinical Commissioning Group	Clinical Services Review Joint Committee	To provide an update to Members
Forward Plan	Dorset Health Scrutiny Committee	Forward Plan – Dates of future meetings, including planned agenda items	To raise awareness of future agenda items, meetings, workshops and seminars.

Briefings for information / note

Agenda planning meetings (Officers' Reference Group only)			
Date	**Venue**	**Papers required by Health Partnerships Officer**	**Papers dispatched by Democratic Services**
TBC – late December or early January (for Committee on 9 March)	County Hall	15 February 2017	1 March 2017

Workshops and development sessions (all DHSC Members)			
Date	**Venue**	**Topic**	**Comments**
February 2017	TBC	DHSC Annual work programming workshop	To consider the Committee's priorities for the coming year
June / July 2017	TBC	DHSC induction workshop	To support newly elected Members following Council elections in May 2017

Committee dates 2017: 9 March; 16 June; 4 September; 13 November

Ann Harris, Health Partnerships Officer, November 2016

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Bournemouth, Poole and Dorset councils
working together to improve and protect health

Public Health Dorset

Public Health Dorset
Director of Public Health Annual Report 2016

What does Public Health Dorset do?

We work with our three councils and the local NHS to improve people's health and wellbeing.

We commission public health services, such as LiveWell Dorset, drug and alcohol services, sexual health services, and children's health visitors, from central government grants.

We advise and support partners locally to improve health and wellbeing through education, housing, planning and transport.

We create healthy places by supporting organisations to build healthier communities.

We work with national partners, such as Public Health England, to protect local population health.

We collaborate with partners in education to better understand the impact of prevention.

Introduction

Prevention is better than cure. It's obvious, right? Behind this seemingly simple statement lies a pressing and complex challenge.

Successful prevention means longer, healthier lives that place fewer demands on our health and care services and families. Failure means that we will struggle to cope with the increasing demands of more people living in poor health with chronic, but potentially preventable diseases, like heart disease and diabetes.

My report last year focused on the importance of cardiovascular disease – stroke, heart disease and diabetes – because our death rates are starting to rise after decades of decline. My other concerns in that report were the differences in death rates between poor and wealthy parts of the county, and differences in the quality of care.

This year, I have looked at what the health and care system in Dorset can do to address these pressing health and wellbeing challenges, especially cardiovascular disease and diabetes.

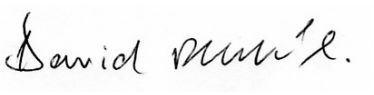
Health and wellbeing varies considerably across Bournemouth, Poole and Dorset. But, compared with most areas of the country, we are mostly healthier and, on average, live for longer. But this is not true for all of us. Health inequality is most visible in Bournemouth, where men living in the poorest areas live on average 10 years less than men in the most affluent areas.

"The NHS and councils in Dorset are committed to closing this health and wellbeing gap. As the chief executive of the NHS Simon Stevens states, unless the NHS and partners take prevention seriously health and care services will be unaffordable."

This report explains our prevention strategy; it describes how we can improve the health and wellbeing of people and free up much needed resources for use elsewhere.

I challenge our health and care system in Dorset to take prevention seriously by implementing a range of measures at scale and pace. This includes individual action, like taking more exercise and losing weight. It includes actions for organisations, for example, ensuring the NHS supports people to live healthier lives. And actions for places: councils and communities working together to ensure that we all live in healthier environments.

This means decent, warm and safe housing. This means transport plans that promote walking and cycling over car use, where practical. This means continuing the excellent work on ensuring access to high quality outdoors space, especially green space, for all.



Dr David Phillips
Director of Public Health Dorset

The prevention challenge in Dorset

About one in every six people who died in Bournemouth, Poole and Dorset between 2012 and 2014 did so from conditions that are considered preventable. This is about 4,000 people.

Heart disease, some cancers, and respiratory disease are among the leading causes of these preventable deaths.

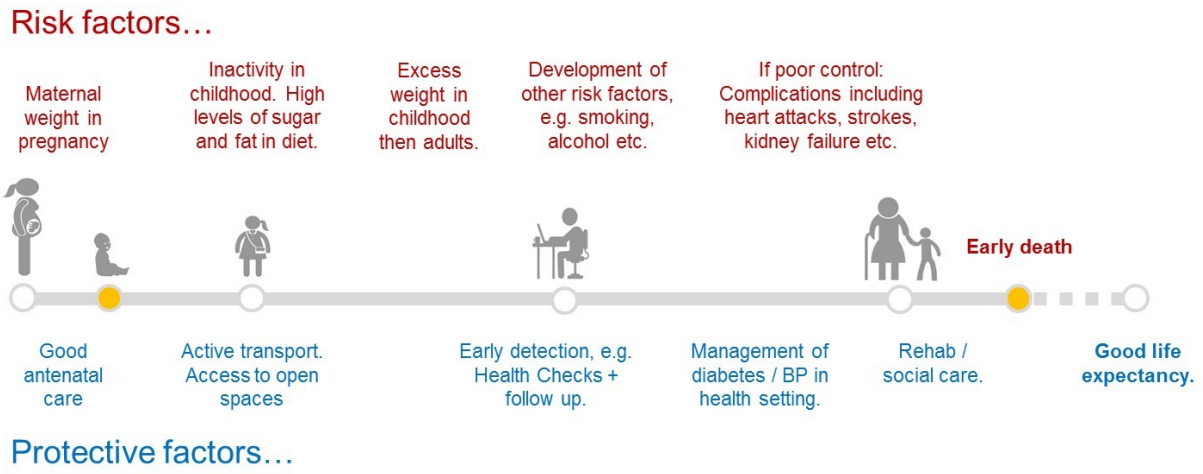
It is not just the avoidable deaths that are important. It is the impact on our families, communities, and health care system. Our system is struggling to find enough money, time and people to cope with the demands being placed on it.

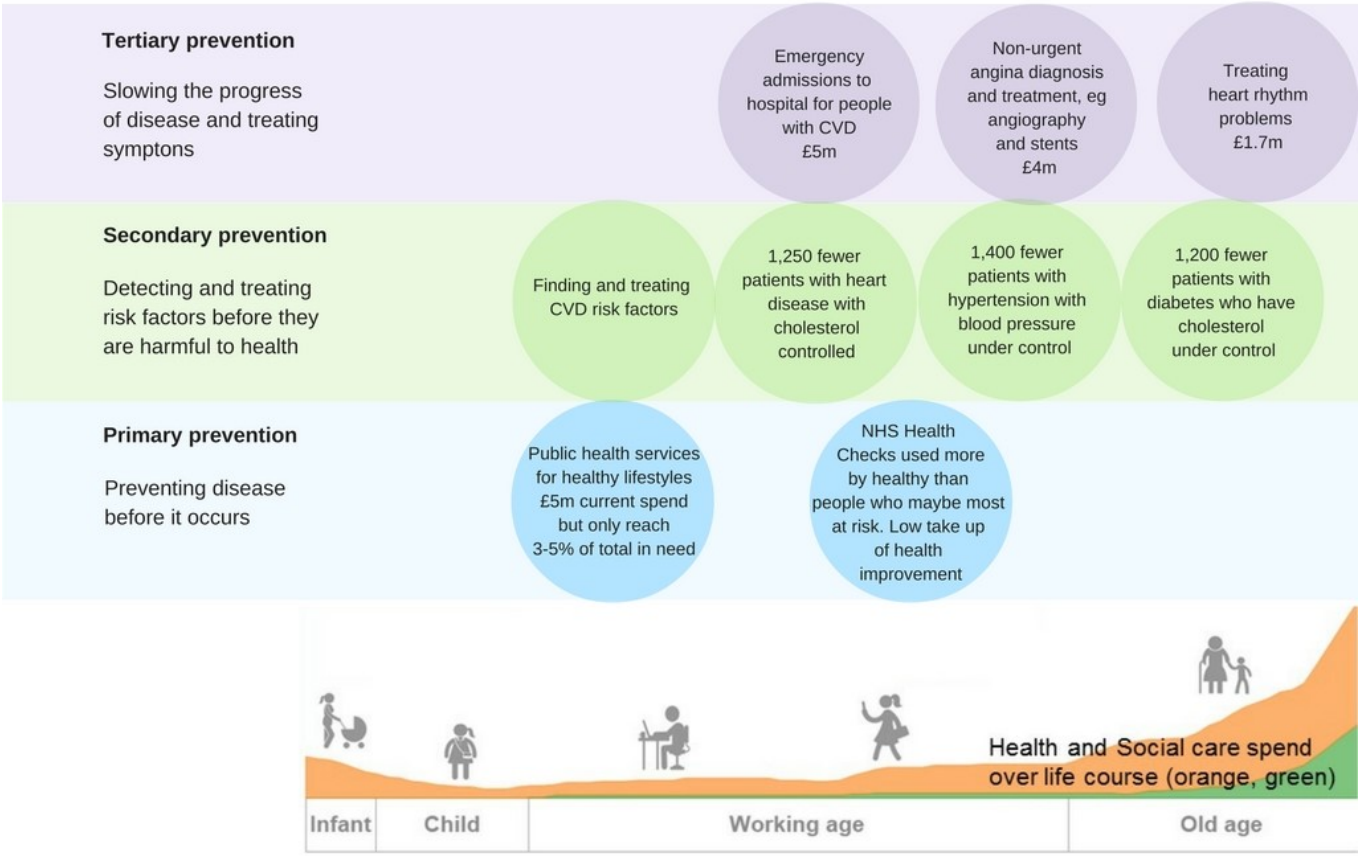
Preventable conditions contribute to this pressure. Dorset spends much more money each year treating people with cardiovascular conditions than areas with similar populations. In total, our additional cost has been estimated at more than £8 million, compared with areas with similar populations.

Preventing more people developing cardiovascular diseases in the first place will reduce the burden on the health system.

The diagram below shows selected risk factors, by life stage, for cardiovascular disease, along with some important protective factors.

On page four, selected costs and opportunities are highlighted for improving prevention in cardiovascular disease.





Selected costs and opportunities for improved prevention in cardiovascular disease. Source: NHS Right Care Commissioning for Value Focus Pack April 2016 / Public Health Dorset

Taking action throughout the lifecourse

Our first challenge is to identify the risk factors we should focus prevention activities upon. Which risk factors most contribute to the development of these preventable conditions? How can we make the biggest impact?

Behavioural or 'lifestyle' risks affect the people the most. They include diet, lack of physical activity, being overweight, smoking, or misusing alcohol or other drugs. Underlying these behaviour risk factors, there are more complex environmental or 'place based' risk factors that may affect entire communities.

These include access to green space, quality housing, good jobs, a decent income, good education, physically safe environments, and healthy social engagement with your community.

Conversely, we want to limit exposure to poor air quality, overcrowding, crime and violence, or other harmful substances, such as those that are toxic or pathogenic.

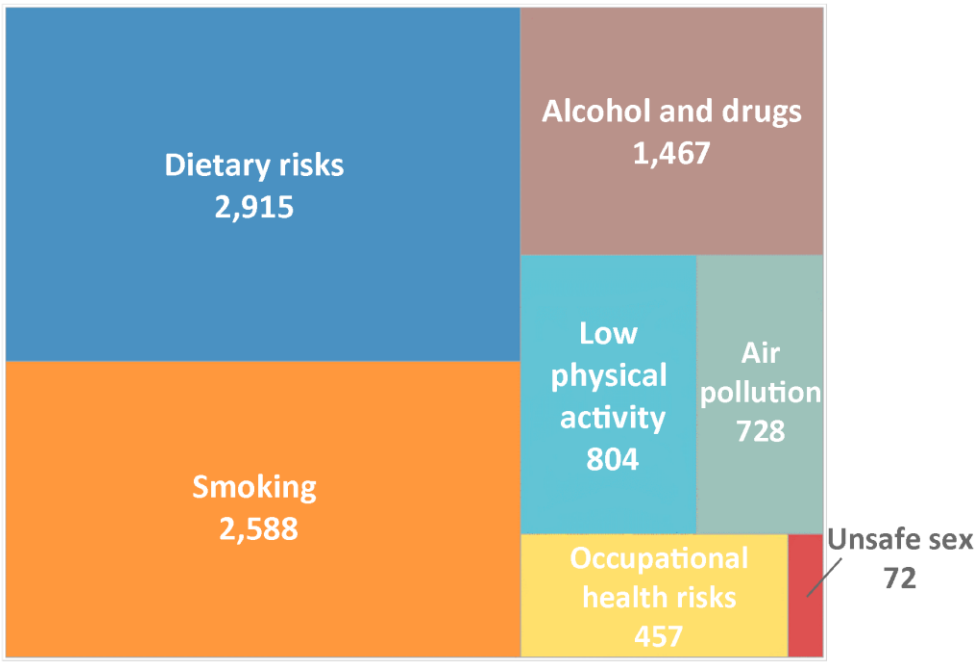
These risks accumulate throughout your life. They affect your chance of an early death from heart disease or diabetes. These same behaviour risks are responsible for a large amount of the ill-health people experience, often starting in middle age.

This means we must take action in all stages of life, but the earlier the better, to improve the health and wellbeing of the population. And ultimately reduce the amount of preventable disease, death and disability.

Factors that make the greatest contribution to disease in Dorset

Relative importance by risk factor for south west England 2015.

(Disability life-adjusted years (DALY) per 100,000 people)



Source: Global Burden of Disease Study 2015

This report started with a proposition. There are actions we can take now, some of which are currently underway, which will improve local people's health and wellbeing.

But currently these interventions are not delivered widely or quickly enough to significantly reduce the burden of preventable disease, early death and disability.

We have set out a menu of actions at three important life stages that we believe should form the core of a prevention strategy.

They are not comprehensive, but designed to start the debate. We also need to change the way that organisations support people to reduce their risks, or in the case of places, improve health and wellbeing through other approaches like better housing, transport, jobs, or education.

Overall, our actions are designed to help people **move more, eat better, quit smoking and drink less alcohol**.

Some actions, in the earliest phase of life, are aimed at creating the best foundation for health, including being more resilient, and having good mental health.

Supporting prevention at scale

	Starting well	Living well	Ageing well
People	Reduce the number of people smoking in pregnancy in the most deprived areas by ensuring the right support is available to refer to stop smoking services Develop clearer healthy lifestyles support for families and children, by encouraging closer working between LiveWell Dorset and the new integrated 0-5 services Implement the emotional health and wellbeing strategy. Better support for mental health and resilience interventions to reduce risky behaviours	Aim for a change in proportion of people supported by LiveWell Dorset following an NHS Health Check – from 3% to 15% Evaluate COM-B based coaching to see if it results in long term behaviour change Develop more sophisticated behaviour change campaigns working with PHE and local partners	Personalised support planning for people with long term conditions using House of Care model Monitor percent of health checks that identify people at high risk to ensure they are reaching communities most in need Support development of peer support for people living with cardiovascular disease and diabetes, such as the Health Helpers
Organisations	Improve early food habits by rolling out Food for Life programme for all early years settings and schools Train more teachers in behaviour change skills Challenge schools to boost the amount of time allowed for physical activity and get more children walking and cycling to school	Provide alcohol brief interventions in hospitals and primary care, not just in the community Provide more brief interventions for physical activity in primary care, working with LiveWell Dorset Continue to build capacity and expertise in behaviour change for frontline NHS and public sector staff. Implement NHS England All Our Health/Making Every Contact Count Establish lifestyle clinics for planned elective care to reduce smoking and increase physical activity	Reduce observed variation in proportions of people living with cardiovascular disease and diabetes adequately treated Extend expertise of LiveWell Dorset's behavioural coaching into other services for people living with long term conditions, such as My Health My Way and rehabilitation for cardiac and respiratory diseases
Places	Ensure free funded nursery places for two year olds in the most deprived areas are fully taken up Invest in quality play areas, green spaces, and encourage more walking and cycling Support resident-led play schemes similar to ones in Bristol and London (Playing out, Play Streets) Consider using planning notices to limit fast food outlets near schools Commission physical activity schemes such as Beat the Street and deliver at scale	Ensure transport and planning support active travel (walking and cycling) over car use where practical Establish health and wellbeing objectives in local and neighbourhood planning frameworks as a clear objective Extend initiatives that support people to access high quality green space – the Natural Health Service	Healthy homes – increase numbers of people living with cardiovascular disease and respiratory conditions supported to have a warm and safe home Develop community-led and population-based approaches to chronic disease management, using peer support such as the Health Helpers Ensure integrated community services plans take a place-based approach, working with primary care at scale

Join our Dorset prevention challenge

This report has shown that there are real opportunities in Dorset to prevent the development of major killers like cardiovascular disease by helping people and communities improve their health and wellbeing.

By getting more people moving, eating better, having fewer unhealthy habits, such as smoking and drinking too much, and looking after our mental health, fewer people will develop the risks that over time lead to the development of these conditions.

This is not only good for people, families and places, but will help our health and care system be more affordable in the longer term.

Act now for the future

We have identified actions, by organisation, place and individuals, at important stages of life.

Taken together, these could form the basis of a comprehensive, ambitious programme to deliver prevention at scale and pace in Dorset.

We now need local partners in the health and care system in Dorset to come together and identify which of these make most sense, and could be implemented quickly and at scale to make a difference.

The two Health and Wellbeing Boards in Dorset will jointly lead this work, as a core aim of their Joint Health and Wellbeing Strategies.

However, it is not the sole responsibility of the boards – and while they will provide the local leadership for prevention, the action rests with us all.

During the autumn of 2016, the boards will host Prevention at Scale workshops. At these, partner organisations across the Dorset health and care system will be asked to identify the interventions and approaches that make most sense for Dorset, and their organisation.

This will be used to develop the final delivery plan for prevention at scale, guided by the aims of the Joint Health and Wellbeing Strategies, and Sustainability and Transformation Plan, Our Dorset.

Join us on this challenge. Together, we can make a difference.

This means healthier lives, communities, thriving places, and securing the future for our health and care system in Bournemouth, Poole and Dorset.

Glossary

Health inequality (also known as the 'health and wellbeing gap')	The measurable differences in health and wellbeing between communities and groups in any area, such as the 10 year life expectancy difference for men in Bournemouth.
Cardiovascular disease	Diseases such as heart disease, stroke, diabetes and chronic kidney disease
Sustainability and Transformation Plan (STP)	A local plan for health and care that sets out the actions required to make services sustainable and affordable, while reducing health inequality. It sets out how the NHS and councils will work together to achieve this, including carrying out plans for prevention.
Place-based approach to health	Takes a 'place' or community as the starting point for protecting and improving people's health, and asks what helps keep people healthy. This is in contrast to the traditional disease-based or health provider-centred approach.
Prevention at scale	Interventions that aim to reduce the risk of developing disease and ill health, rather than limit the effects of disease once it has already developed. There are good examples in Dorset of these interventions, but much of this activity is not yet deployed at scale by the NHS or partners.
Lifecourse	The different stages of life, throughout which different risk factors affect the chance of a person staying healthy in the future and avoiding the development of preventable diseases
DALY (Disability Adjusted Life Year)	A way of measuring the impact of a disease on a population. It combines numbers of years spent living with disability, with number of years lost to early deaths from the condition.

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